

**NAVAL HOSPITAL CHARLESTON
COMMAND HISTORY FOR 1995**

MISSION STATEMENT:

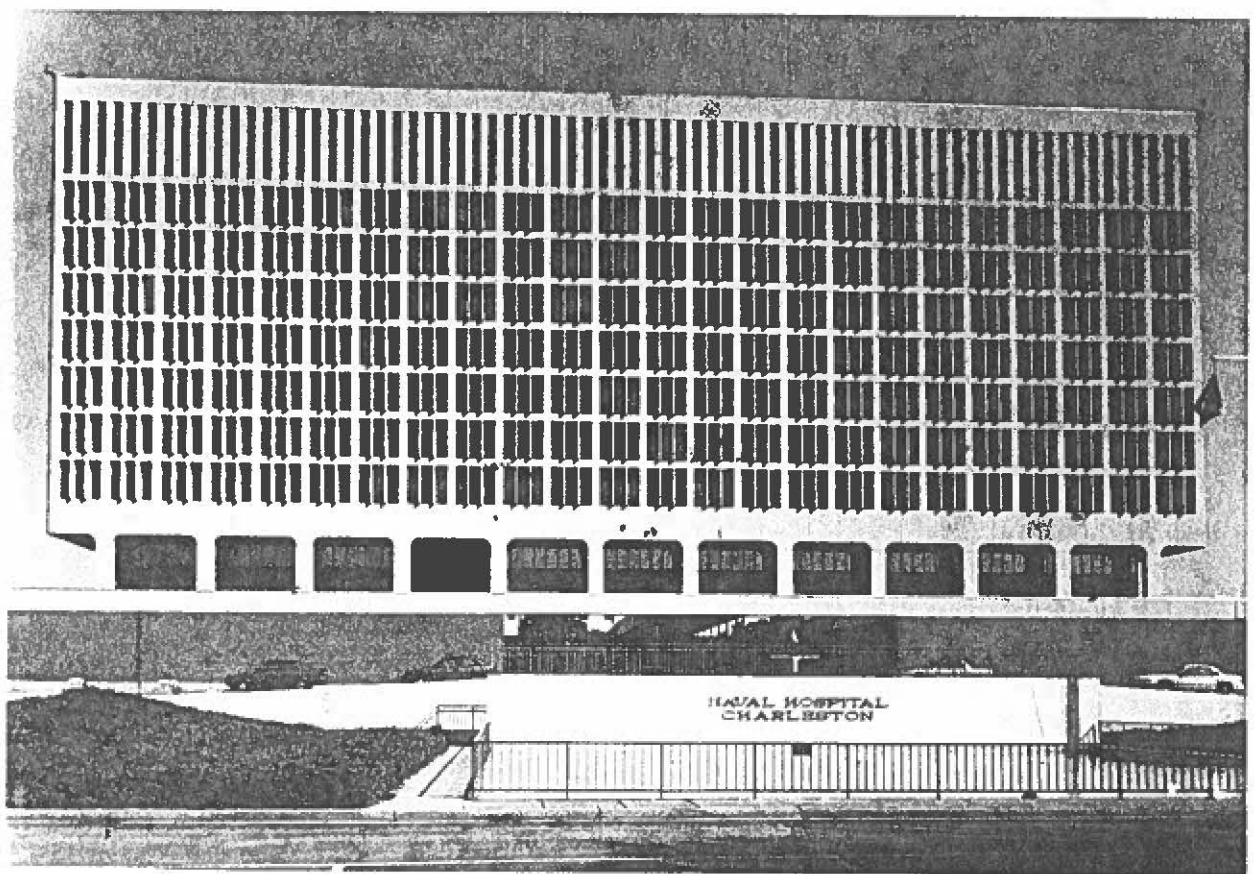
Our mission is to keep the active duty members of all Armed Services healthy, and to provide healthcare to their families and other beneficiaries entrusted to our care.

VISION STATEMENT:

Our vision is to be the model primary care community hospital in an integrated Department of Defense managed healthcare delivery system.

GUIDING PRINCIPLES:

- Customer service will be our primary focus in all decision making.
- Recognize that our primary mission is to support combat readiness.
- Manage the delivery of healthcare services, balancing access, quality, and cost containment.
- Care for all persons as unique human beings worthy of our best professional efforts applied with courtesy, compassion, and respect.
- Guard against inflexibility which interferes with meeting the needs of our customers.



NAVAL HOSPITAL CHARLESTON, SC

PAST

- Constructed in 1973
 - Commissioned as a 318 bed facility
 - Satellite clinics located at Naval Weapons Station, Naval Shipyard, and the Naval Station
- Served in excess of 100,000 beneficiaries
- Staffing level in excess of 1,300 (100 MDs)

PRESENT

- Designated and staffed as 40 bed facility
 - Satellite clinics located at Naval Weapons Station and Naval Shipyard
- Service a beneficiary population of 72,000
 - 10,000 Active Duty
 - 27,000 Active Duty Family Members
 - 35,000 Retired and Retired Family Members
- Staffed at 1,004 employees (160 Officers, 460 Enlisted, 384 Civilians)
 - 49 MDs on staff
 - 6 AF Officers: 1 O-6 MSC XO, 1 O-3 MD, 2 O-3 MSC Business Managers, 1 O-3 MSC Analyst, 1 O-3 MSC Health Promotion Officer
- Received accreditation from the Joint Commission on Accreditation of Healthcare Organizations in May 1995
- Operating budget of \$37.5M in FY95
- Workload for FY95:
 - Average Daily Patient Load: 35
 - Total Inpatient Admissions: 5,301
 - Total Outpatient Visits: 287,292
- Specialty Service Capabilities: Family Practice, Pediatrics, Internal Medicine, OB/GYN, Emergency Medicine, ENT, Dermatology, General Surgery, Urology, Mental Health, Ophthalmology, Optometry, Dental, Health Promotions, Nutritional Medicine, Social Work, Audiology, Occupational Health, Physical Therapy, Occupational Therapy Preventive Medicine, Industrial Hygiene, Radiation Health.

- Partnership Programs:
 - Internal: Radiology, Gynecology, Obstetrics, Cardiology, Pediatric Ophthalmology, Primary Care Clinic
 - External: Urological Lithotripsy, OB/GYN/Newborn Nursery/Pediatrics

CHAMPUS TOTAL INPATIENT AND OUTPATIENT CARE EXPENDITURES FY94

Total Government Cost	\$ 28,240,624
Total Patient Cost	8,767,121
Total Government & Patient Cost	37,007,745

FUTURE

- Anticipate bed designation to remain stable at 40
 - Naval Weapons Station clinic to remain open, Shipyard clinic scheduled to close in February 1996
- Beneficiary population will drop to 68,000 in FY96
 - 8,000 Active Duty
 - 22,000 Active Duty Family Members
 - 38,000 Retired and Retired Family Members
 - 3,500 of Retired & Retired Family Members are over 65 (5.2%)
- Staffing will be reduced to 754 (136 Officers, 244 Enlisted, 374 Civilians)
 - Anticipate 42 MDs on staff
- No immediate changes or terminations of specialty services anticipated
- Partnership Programs will either be terminated or changed to Resource Sharing agreements under the requirements of TRICARE
- TRICARE will be implemented in May/June 1996
 - A triple option healthplan that allows beneficiaries to select their health coverage: Tricare Prime (HMO), Tricare Extra (PPO), or Tricare Standard (Indemnity)

Date as of 03 Nov 95
CS/CH

COMMAND ORGANIZATION:

Commanding Officer:

Captain H. Birt Etienne, Medical Corps, USN
01Jan95 - 22Jul95

Captain Kathleen L. Martin, Nurse Corps, USN
22Jul95 - 31Dec95

Executive Officer:

Colonel Stephen L. Langenberg, Medical Service Corp,
USAF, 01Jan95 - 10Aug95

Colonel John A. Lee, Medical Service Corp, USAF,
10Aug95 - 31Dec95

Command Master Chief:

HMCN (SW)/(AW) B.R. Boyd 01Jan95 - 01May95

HMCN (SS) G.L. Becker 01May95 - 31Dec95



CAPTAIN H. BIRT ETIENNE
MEDICAL CORPS, UNITED STATES NAVY

Captain Etienne was born in Highland Park, Michigan. He graduated from Michigan State University in 1961 with a Doctor of Veterinary Medicine Degree. He received a Masters of Science Degree from Michigan State University in 1963 and his Doctor of Medicine from the University of Michigan in 1967. He completed his Internship in 1968 at St. Joseph Mercy Hospital in affiliation with the University of Michigan.

After one year of General Surgery training he entered the United States Navy as a Lieutenant, and served as Medical Officer of USS ST. PAUL (CA-73) off the coast of Vietnam in 1969 and 1970. He served as a Staff Medical Officer at Marine Corps Recruit Depot, San Diego until his release from active duty in 1971. He completed his residency training at St. Joseph Mercy Hospital/ University of Michigan Medical School in Ann Arbor and entered private practice at the Burns Clinic Medical Center, Petoskey, Michigan. He maintained his commission in the United States Naval Reserve and re-entered active duty in 1979.

Captain Etienne has served as Commanding Officer, Naval Hospital, Charleston; Staff Surgeon, Naval Hospital, Portsmouth, Virginia; Director, Surgical Services and Head, General Surgery at Naval Hospital, Jacksonville, Florida; Director, Surgical Services and Program Director in General Surgery at National Naval Medical Center, Bethesda, Maryland; and Executive Officer, Naval Hospital, Portsmouth, Virginia. In addition, he also served as Head, MMART Surgical Team 6 in Beirut, Lebanon, and as Ship's Surgeon, USS INDEPENDENCE (CV-62).

Doctor Etienne is a Fellow of the American College of Surgeons and is certified by the American Board of Surgery. His faculty appointments have included Assistant Professor of Surgery at Eastern Virginia Medical School, Professor of Clinical Surgery at the University of Florida, and Associate Professor of Clinical Surgery at Uniformed Services University of the Health Sciences. He has been awarded the Legion of Merit, Meritorious Service Medal with Gold Star in lieu of Third Award, Navy Commendation Medal, Navy Achievement Medal, National Defense Service Medal, Navy Expeditionary Medal, Vietnam Service Medal and Vietnam Campaign Medal.

Captain Etienne is married to the former Kayleen A. Kernstock of Bay City, Michigan. He has four children, David (wife Carmen), John (wife Melissa), Robert (wife Kathleen), and Michael; and five grandchildren, Andrew, Eleanor, Sara, Ian and Miriam.



CAPTAIN KATHLEEN L. MARTIN
NURSE CORPS, UNITED STATES NAVY

A native of Arnold, Pennsylvania, Kathleen L. Martin was commissioned an Ensign in May 1973 while in the Nurse Corps Candidate Program. Following officer indoctrination in Newport, Rhode Island, she served at Naval Hospital, Camp Lejeune, North Carolina, as a staff nurse and later a charge nurse in pediatrics. In 1976, she reported to Navy Recruiting District, Philadelphia, as the medical programs officer.

From 1979 to 1982, Captain Martin was assigned to Naval Hospital, Jacksonville, Florida, as the charge nurse of the pediatric ward. Following this tour of duty, she was reassigned to Naval Medical Clinic, Pearl Harbor, Hawaii. During this period her duties included Nursing Division Officer of Military Medicine, Credentials Coordinator, Risk Manager, Quality Assurance Coordinator, and additional educational assignments.

In 1986, she was transferred to Naval Hospital, San Diego, California, and served as Head of the Ambulatory Medical Nursing Department, which encompassed eight medical specialty clinics. Captain Martin attended the University of San Diego from 1990 to 1992, earning a Master of Science Degree in both nursing administration and as a family health nurse specialist. Following duty under instruction, she was assigned to Naval Medical Clinic, Port Hueneme, California, as the Director of Nursing Services.

Captain Martin assumed her first command in 1993 as Commanding Officer of Naval Medical Clinic, Port Hueneme. She became Commanding Officer, Naval Hospital, Charleston, South Carolina, in July 1995.

Captain Martin is a 1973 graduate of Boston University. Military decorations include the Legion of Merit, the Meritorious Service Medal and the Navy Commendation Medal. She is married to Captain Walter P. Martin, USN (Ret) of Gulfport, Mississippi. They have three children: Jennifer; Walter, Jr.; and Christopher.



COLONEL JOHN A. LEE
United States Air Force, Medical Service Corps

Colonel John A. Lee is the Executive Officer, Naval Hospital Charleston. He succeeded Colonel Stephen L. Langenberg who retired 11 August, 1995.

Colonel Lee was commissioned a second lieutenant through the Reserve Officer Training Corps program in 1972 and entered the Air Force in the missile operations career field in 1973. He received a regular commission in 1975. Colonel Lee resigned his Line of the Air Force Commission and was recommissioned in the Medical Service Corps in 1978. He has served as an instructor and missile combat crew deputy commander and commander; medical squadron section commander; assistant director, medical resource management; administrative assistant, department of medicine; director of patient administration, director of medical plans and operations; Air Force inspection team chief; and hospital administrator. Colonel Lee led the first medical elements of the 4th Tactical Fighter Wing to Thumrait, Oman, in support of Operation Desert Shield and led elements with the 366th Medical Group, in support of Operation Restore Hope and United Nations Operations in Somalia II.

Colonel Lee is married to the former Stephanie D. Rumbley of Moss Point, Mississippi. They have four sons, Charles, Jeff, Frank, and Gary.

EDUCATION:

1972 Bachelor of Science Degree in Biological Science, Auburn University
1976 Master of Arts Degree in Public Administration/Human Relations, Webster College
1976 Squadron Officer School, Correspondence
1977 Squadron Officer School, in Residence
1981 Air Command and Staff College, Seminar
1987 National Security Management, Correspondence
1994 Air War College, Correspondence

ASSIGNMENTS:

1. July 1973 - April 1978. Instructor, Standardization/Evaluation Missile Combat Crew Deputy Commander, Commander, 308th Strategic Missile Wing, Little Rock AFB, Arkansas
2. April 1978 - June 1981. Medical Squadron Section Commander, Assistant Director, Medical Resource Management, Administrative Assistant, Department of Medicine; USAF Medical Center Keesler, Keesler AFB, Mississippi
3. June 1981 - June 1983. Director of Patient Administration, Director of Medical Plans and Operations; USAF Clinic Hickam, Hickam AFB, Hawaii
4. June 1983 - June 1986. Medical Plans Internship Program, Assistant Chief of Medical Plans and Operations; Office of the Command Surgeon, Headquarters U. S. Air Forces Europe, Ramstein AB, Germany
5. June 1986 - June 1988. Team Chief, Air Reserve Component Inspection Division; Member Active Duty Inspection Team, Air Force Inspector General at Headquarters Air Force Inspection and Safety Center, Norton AFB, California
6. June 1988 - December 1990. Hospital Administrator, 4th Medical Group, 4th Tactical Fighter Wing, Seymour Johnson AFB, North Carolina

7. December 1990 - August 1993. Administrator, 366th Medical Group, Mountain Home AFB, Idaho
8. September 1993 - June 1995. Administrator, Headquarters 72d Medical Group, Tinker Air Force Base, Oklahoma
9. July 1995 - Current. Executive Officer, Naval Hospital Charleston, Charleston, South Carolina

MAJOR AWARDS AND DECORATIONS:

Air Force Meritorious Service Medal with six oak leaf clusters
Air Force Commendation Medal
Air Force Achievement Medal with two oak leaf clusters
Small Arms Expert Ribbon with star
Combat Readiness Medal
National Defense Service Medal with one oak leaf cluster
Air Force Excellence Ribbon
Air Force Outstanding Unit Award with two oak leaf clusters
Southwest Asia Service Medal
Air Force Training Ribbon

OTHER ACHIEVEMENTS:

Diplomate (Board Certified Member) of the American College of Healthcare Executives

EFFECTIVE DATES OF PROMOTION:

Second Lieutenant	8 December 1972
First Lieutenant	5 January 1974
Captain	5 July 1976
Major	1 May 1984
Lieutenant Colonel	1 April 1990
Colonel	1 March 1995

(Current as of 1 September 1995)



**HCMCM(SS) GARY L. BECKER
COMMAND MASTER CHIEF**

A native of San Diego, California, Gary L. Becker enlisted in the United States Navy October 1971 and reported to Naval Training Center, San Diego, California, for basic training. After completing basic training he went through Hospital Corpsman school also in San Diego. Upon graduating Corps school he reported for duty in May 1972 to National Naval Medical Center, Bethesda, MD. He spent his first year working in the Intensive Care Unit before being reassigned to the Washington Navy Yard Branch Medical Clinic. An application for "Brother Duty" took him to Naval Hospital, San Diego, California in October 1973. ,

After graduating from Surface Independent Duty Corpsman school in February 1976, Master Chief Becker reported to Fleet Marine Force training at Camp Pendleton, California, then transferred to Third Force Service Support Group Okinawa, Japan, in June 1977. In July 1978, he changed duty stations to the Bureau of Naval Personnel, Washington D.C., and served as the HM Detailer for clinical Navy Enlisted Classification Codes.

From January to October 1981, Master Chief Becker attended Submarine Independent Duty Corpsman school in Groton, Connecticut, and upon graduation reported to USS Batfish (SSN 681). After three years, he was reassigned to the Naval Hospital, Jacksonville, Florida. In April 1987, he transferred to Submarine Squadron FOUR, Charleston, South Carolina. He returned to the Bureau of Naval Personnel as the Enlisted Community Manager for the HMs and DTs in June 1992. Three years later, he was transferred to his current tour as Command Master Chief, Naval Hospital, Charleston, South Carolina.

Master Chief Becker is married to the former Connie K. Pruett of Fort Collins, Colorado. They have two daughters, Kimberly, and Kaylan. His military decorations include two Navy Commendation Medals and two Navy Achievement Medals.

COMMAND ORGANIZATION KEY STAFF MEMBERS:

Commanding Officer

CAPT K. L. Martin, NC, USN

Executive Officer

Col J. A. Lee, USAF, MSC

Director for Administration

CDR P. W. Lund, MSC, USN

Director for Patient Services

CAPT M. A. Southerland, NC, USN

Director for Clinical Services

CAPT J. J. Vicens, MC, USN

Director for Managed Care

CDR M. M. Allard, NC, USN

Comptroller

LT G. L. Creech, MSC, USN

- 00TQ TOL COORDINATOR
- 00CE COMMAND EVALUATION
- 00SH SAFETY OFFICE
- 00PC PASTORAL CARE
- 00L LEGAL OFFICE
- 00E CMEO
- 00SM SECURITY MANAGER

-00 COMMANDING OFFICER

-00C COMMAND MASTER CHIEF

- 09PI PERFORMANCE IMPR COORD
- 09MS PRESIDENT OF MED STAFF
- 09PA PUBLIC AFFAIRS OFFICER
- 09PC PATIENT CONTACT REP
- 09SO SECURITY OFFICER

-09 EXECUTIVE OFFICER

-09C COMPTROLLER/FISCAL



- 011 FOOD MANAGEMENT
- 012 MANPOWER MANAGEMENT
- 013 MANAGEMENT INFORMATION
- 014 FACILITIES MANAGEMENT
- 015 PATIENT ADMINISTRATION
- 016 OPERATING MANAGEMENT
- 017 MATERIALS MANAGEMENT
- 018 STAFF ED & TRAINING

- 021 PHYS & OCC THERAPY
- 022 INPATIENT NURSING
- 023 RESPIRATORY THERAPY
- 024 OCC HEALTH & PREV MED
- 025 BRANCH CLINICS
- 026 SOCIAL WORK
- 027 HEALTH PROMOTION AND WELLNESS

- 03B DEPUTY DCS
- 03BM BUSINESS MANAGER
- 03C GROUP PRACTICE RED
- 03D GROUP PRACTICE GOLD
- 03E GROUP PRACTICE BLUE
- 03F PERIOP & AMB SERVICES
- 03G OTORHINOLARYNGOLOGY
- 03H MENTAL HEALTH
- 03J DENTAL
- 03K ANESTHESIA
- 03L LABORATORY
- 03M OPHTHALMOLOGY
- 03N ORTHOPEDIC
- 03P PHARMACY
- 03Q OPTOMETRY
- 03R RADIOLOGY
- 03T DERMATOLOGY
- 03U UROLOGY
- 03W EMERGENCY MEDICAL SERVICES
- 03X PRIMARY CARE CENTER
- 03Y EMERGENCY ROOM

- 041 ALTERNATE HEALTH CARE
- 042 MARKET ANALYSIS

00 COMMANDING OFFICER - CAPT Martin

00C Command Master Chief - HMCM Becker
00C.1 Career Counselor - HMCS Wood
00CE Command Evaluation Officer - Chuck Jackson
00SH Occupational Safety and Health Manager - Jim Carroll
00PC Pastoral Care - LCDR Paris
00L Legal Officer - LT Doyle
00E Command Managed Equal Opport Coord - CDR J. Miller
00SM Security Manager - LT Dula

09 EXECUTIVE OFFICER - Col Lee

09C Comptroller - LT Creech
09C.1 Financial Management Division - Lynda Stewart
09C.2 Business Office Division - Carol Momeier
09C.2B Business Office
09C.2I Insurance
09C.2T Travel
09PI Performance Improvement Coordinator - CAPT Mapes
09PI.1 Risk Manager - LTJG Harris
09PI.2 Infection Control Coordinator - Stacy Brophy
09PI.3 Total Quality Leadership Coordinator
09MS President of the Medical Staff - LCDR Gawith
09MS.1 Chairman of Credentials - CDR Holbrook
09MS.2 Professional Affairs Coordinator - Ann Clack
09PA Public Affairs Officer - LT Kupper
09PA.1 Volunteer Coordinator - Lynn Treadway
09PC Command Patient Contact Rep - HMCS Epstein
09SO Security Officer - OCSG Rutherford

01 DIRECTOR FOR ADMINISTRATION - CDR Lund

011 Nutrition Management Department - Linda Washington
011.1 Administration & Stores
011.2 Clinical Nutrition
011.3 Production & Service
012 Manpower Management Department - LT Cullen
012.1 Personnel Services
012.2 Plans, Operations, and Medical Intelligence
012.3 Reserve Liaison
013 Management Information Department - LCDR Ricker
013.1 Information Systems Security & Systems Mngt
013.2 Biostatistics & Training
013.3 Systems Operations
013.4 Life Cycle Management
013.5 CHCS Projects
013.6 Data Base Management
013.7 Telecommunications
014 Facilities Management Department - LTJG Marincasiu
014.1 Maintenance & Repair
014.2 Transportation
015 Patient Administration Department - LCDR Albia
015.1 Inpatient Administration
015.11 Admissions
015.12 Medical Boards
015.13 Medevac
015.14 Decedent Affairs
015.15 Disability Counselor
015.2 Medical Records
015.21 Inpatient Records
015.22 Outpatient Records
016 Operating Management Department - LT Dula
016.1 Administrative Services
016.2 Security
016.3 General Services
016.4 Environmental Services
016.6 BEQ
017 Materials Management Department - LT Knotts
017.1 Purchasing
017.2 Material
017.3 Equipment Management
018 Staff Education and Training Department - CDR J. Miller
018.1 Life Support
018.2 Learning Resources
018.3 Professional Development
018.4 Follow-On Training
018.5 Administrative Support
018.6 Emergency Medicine

NAVAL HOSPITAL CHARLESTON ORGANIZATION (4AUG95)

02 DIRECTOR FOR PATIENT SERVICES - CAPT Savige

021 Physical/Occ Therapy Department - LTJG Allen
022 Inpatient Nursing Department - LCDR Fricker
022.1 Post Anesthesia Care
022.2 Same Day Surgery
022.3 Medical/Surgery Nursing
022.4 Critical Care
022.5 Nursing Education
022.6 Nursing Quality Improvement
023 Respiratory Therapy Department - HM1 Roberts
024 Occ Health & Preventive Med Dept - CDR Williams
024.1 Occupational Health
024.2 Industrial Hygiene
024.3 Preventive Medicine
024.5 Immunizations
025 Branch Clinics
025.1 Naval Weapons Station Branch Clinic - CDR Kimball
025.2 Naval Sta Branch Clinic - LCDR Robertson
026 Social Work Department - LT Fuller
027 Health Promotion & Wellness Department - Capt Hockman
028 Periop & Ambulatory Serv Department - CDR Netzer
028.1 Main Operating Room
028.2 Ambulatory Services
028.3 Central Sterile Supply

03 DIRECTOR FOR CLINICAL SERVICES - CDR Vicens

03B Deputy Director - CAPT Llibre
031 Group Practice Red - LCDR Dye
032 Group Practice Gold - CDR Elwood
033 Specialty Support Department - CDR Kerrigan
033.1 Obstetrics/Gynecology
033.2 Surgery
033.3 Dermatology
033.4 Otorhinolaryngology
033.5 Urology
033.6 Orthopedics
033.7 Ophthalmology
033.8 Optometry AFB
033.9 Optometry NWS
034 Ancillary Department - CAPT Llibre
034.1 Laboratory
034.2 Radiology
034.21 Radiation Health
034.3 Pharmacy
035 Mental Health Department - CAPT Cusack
036 Dental Department - LCDR Smith
037 Emergency Medical Serv Department - CDR Dickerson
038 Anesthesia Department - CAPT Nagel
03X Primary Care Center - Dr. Steinman
03Y Emergency Room - Dr. Rivera-Pena

04 DIRECTOR FOR MANAGED CARE - CDR Allard

041 Alternate Health Care Department - LCDR Benninger
041.1 Health Care Finders
041.2 Health Benefits Advisor
041.3 Purchased Health Care
041.4 Outpatient Support Services
041.5 Utilization Management
041.6 Empanelment
041.7 Case Management
041.8 Discharge Planning
042 Market Analysis Department - LCDR Storey
042.1 Marketing
042.2 Provider Relations
042.3 Planning & Analysis

BOARDS, COMMITTEES, AND COLLATERAL ASSIGNMENTS

Accreditation Committee
Advancement Exam Coordinator
Antineoplastic Drug Officer
Audit Board Collection Agent
Auditor of Patient Valuables
Awards Board Committee
BEQ Advisory Board
Blood Team
Child Abuse Committee
CHCS Management Team
Civilian Drug-Free Workplace Coordinator
Command Assessment Team
Command Time Card Audit Board
Controlled Medicinal Inventory Board
Credentials Committee
Critical Care Committee
Decedent Affairs Officer
Discharge Planning Team
Drug and Alcohol Prevention
Drug Detection Deterrence
Emergency Preparedness Committee
Enlisted Performance Review Board
Equal Employment Opportunity Committee
Equipment Review Committee
Executive Committee of Medical Staff
Executive Steering Council
Family Advocacy Committee
Financial Specialist
Fire Warden
Healthcare Consumer Council
Health Information/Medical Records
Health Records Program Administrator
Human Immunodeficiency Virus Coordinator
Information Systems Executive Board
Information Systems Security Manager
Invasive Procedures and Transfusion
Management Control Program Officer
Mobile Medical Augment Readiness
Morale, Welfare, and Recreation Committee
Occupational Safety and Health/Hazardous Material Control Committee
Occupational Safety and Health Council
Organ and Tissue Procurement Team
Partnership Program Review Committee
Performance Improvement/Risk Management
Personal Excellence Partnership Program
Pharmacy and Therapeutics Committee
Physical Fitness Coordinator
Physical Security Review Committee
Position Management Committee
Postal Officer
Precious Metals Recovery Program
Professional Development Board

BOARDS, COMMITTEES, AND COLLATERAL ASSIGNMENTS (cont.)

Rabies Control Board
Radiation Safety Committee
Radiation Safety Officer
Religious Offerings Fund Custodian
Retention Team
Savings Bond Coordinator
Spouse Abuse Committee
Voting Officer
Watchbill Coordinator
Patient Education Committee
Bioethics Committee
Infection Control Committee
Infection Surveillance Committee
Incentive Awards Committee

The following is a record of events involving the Naval Hospital at Charleston, South Carolina during 1995. It is comprised of functions, developments, operations, concerns, and accomplishments of the command and its staff in chronological order. Personnel awards ceremonies were held throughout the year recognizing staff members with various and service awards along with good conduct and outstanding performance.

JANUARY

01/25-26/95 NAVHOSP Immunization Clinic held a pneumonia vaccine clinic and inoculated over 200 people.

01/95 LCDR Susan Herrold, NC, USN, received the Health Professional Award from the Charleston Trident Dietetic Association.

01/95 NAVHOSP opened a Job Club resource office in conjunction with the Charleston Naval Complex Transition Center.

01/95 The Ambulatory Procedures Unit moved to its new location on 4A.

FEBRUARY

02/01/95 As a result of a Government Reduction In Force, 42 civilian employees opted for early retirement and were honored with a retirement ceremony and luncheon.

02/17/95 Six staff members of Fleet Hospital Five returned from United Nations peacekeeping operations in Zagreb, Croatia, after a six month tour.

02/21/95 Nancy Soles, Medical Records Administrator, was recognized by The Department of Health Administration and Policy, Medical University of South Carolina, with the Outstanding Clinical Site Director Award.

02/21/95 NAVHOSP Patient Administration Department was recognized by the Medical University of South Carolina's 1995 Senior Class of the Health Information Administration Education Program as the best site for clinical rotation.

02/22/95 NAVHOSP Equal Employment Opportunity Committee presented the 1995 Black History Month Program. The event included a choir and guest speaker Evangelist Janet Sparrow.

02/95 Outpatient Records Division passed a milestone by serving over 1 million customers with pre-pulled and refiled medical records.

02/95 NAVHOSP acquired a KTP/532, YAG laser to be located in the Main Operating Room.

02/95 Mrs. Janine M. Bradburn, Secretary to the Director of Patient Services, was awarded the Meritorious Civilian Service Medal for superior performance.

02/95 Between January and February 1995, members of the Pharmacy staff assisted seventh and eighth graders at DuBose Middle School to research nuclear technology and related fields.

MARCH

03/09/95 Charleston Stingrays Hockey team captain Gary Socha made an appearance at NAVHOSP to visit 16 year old cancer patient Joshua McGillivray and presented him with an autographed team jersey.

03/95 NAVHOSP received the Golden Anchor Award for the second consecutive year in a ceremony marking the event. COMNAVBASE Charleston, RADM Oden, presented the award to Commanding Officer CAPT Etienne and the Command Career Counselor HMC Wood.

03/95 Main Operating Room initiates development of critical pathways for surgical DRGs (Laparoscopic Fundoplication). Group leader was LCDR Shari Marsh

03/95 CDR Netzer presented "Cost Benefit Ratio Analysis in the Purchase of a Rigid Container System" at Shea-Artenzen Nursing Symposium in San Diego, CA.

03/95 As part of its community involvement NAVHOSP personnel spent 2 weeks instructing ROTC students at Wando High School in CPR and First Aid.

03/95 Karen Oglesby, Ophthalmology Department, was inducted into local television station channel 5's Hall of Fame in appreciation for her service to NAVHOSP.

03/95 Nine military personal from NAVHOSP volunteered their time and expertise to help the local chapter of Habitat for Humanity by putting up dry-wall in a home being fixed-up for a needy family.

03/95 Ambulatory Procedures Unit is opened for business with a ribbon cutting ceremony

APRIL

04/27/95 NAVHOSP and American Red Cross held a Volunteer Recognition Luncheon and Awards Ceremony. Over 60 volunteers were in attendance.

04/28/95 The Operating Room and Orthopedic Department sponsored a fracture workshop in conjunction with Synthes USA.

04/95 The Department of Perioperative and Ambulatory Services became part of the Director for Clinical Services.

MAY

05/03/95 NAVHOSP held it's quarterly Healthcare Consumer Council Meeting.

05/30/95 NAVHOSP observed Asian/Pacific American Heritage Month with a fair featuring native food, dancing and displays.

05/95 HMCM(SS) Becker took over as Command Master Chief.

05/95 NAVHOSP was surveyed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and granted accreditation for a three year period.

05/95 A display outlining Ambulatory Procedures Unit activity was presented at the Executive Nurses Meeting in Washington D.C.

05/95 Quality Improvement (QI) and Total Quality Leadership (TQL) integrated and created Performance Improvement (PI).

JUNE

06/07/95 The Charleston Chapter of the Federally Employed Women held its annual Awards Training Luncheon.

06/10/95 Pharmacy Department personnel took first place at the "LAFF OLYMPICS" put on by the NAVHOSP First Class Petty Officer Association as part of the Hospital Corps Birthday celebration.

06/95 NAVHOSP personnel sponsored a class of students at E.A. Burns Elementary School enabling them to visit Washington D.C.

06/95 Results were returned from the FY94 Command Assessment Survey. The survey investigated NAVHOSP's personnel awareness on sexual harassment, fraternization, grievances, and Equal Opportunity.

06/95 BUMED Force Master Chief HMCM M. L. Stewart visited NAVHOSP to discuss the new evaluation system.

06/95 Civilian employee and President of Federally Employed Women's local Charleston Chapter, Sandy Mizner won the Martha Lyle Scholarship from the National Federally Employed Women's Program.

06/95 LCDR Mark Bryson received the 1995 Navy Regent Young Healthcare Executive of the Year Award from the American College of Healthcare Executives.

06/95 NAVHOSP observed the 87th Anniversary of the Navy Nurse Corps with a cake cutting ceremony.

JULY

07/22/95 In a Change of Command ceremony held at NAVHOSP, CAPT Kathleen L. Martin NC, USN, relieved CAPT H. Birt Etienne MC, USN, as Commanding Officer of NAVHOSPCHASN, becoming the 34th Commanding Officer. CAPT Martin is the first female Commanding Officer at NAVHOSP and the first Commanding Officer to come from the Nurse Corp. RADM W.J. McDaniel, a former Commanding Officer of NAVHOSP, was the guest speaker.

07/95 Ward 9A opens in NAVHOSP as a Medical/Surgical ward.

07/95 NAVHOSP Comptroller, LT Creech received the honor of Outstanding Chapter President from the National Naval Officers Association.

07/95 A second critical pathway group investigating total knee replacement was initiated. The group leader was LT Michael Adams.

07/95 The Main Operating Room completed ASDP for Surgiserver 2000 (Perioperative Management Information System) and ACCESS narcotic dispenser.

AUGUST

08/10/95 Executive Officer Col Stephen L. Langenberg retired from the USAF after 34 years of service. Col John A. Lee USAF, MSC, assumed the position of Executive Officer.

08/20/95 LCDR Albia was advanced to Diplomate status in the American College of Healthcare Executives.

SEPTEMBER

09/95 The Summer Youth Volunteer Program registered 28 youth volunteers that worked 1800 manhours in a three month over the summer.

09/95 NAVHOSP observed the 48th Birthday of the Medical Service Corp. with a cake cutting ceremony.

09/95 NAVHOSP staff spent a day to help clean up E. A. Burns Elementary school as part of the partnership between the school and NAVHOSP.

09/95 NAVHOSP observed Employee Appreciation Day with a breakfast of coffee and donuts and a special lunch time meal of steak and lobster.

09/95 Outpatient Support Services divested from Alternate Healthcare and was placed under the direction of the Ambulatory Procedures Unit

09/95 Total Quality Leadership training for leadership given by US Air Force Quality Support office.

OCTOBER

10/09/95 NAVHOSP observed the 220th Birthday of the Navy with a cake cutting ceremony.

10/16-20/95 NAVHOSP observed Hispanic Heritage Week with a Chili cook off contest.

10/95 Performance Improvement held off site strategic planning to revise strategic goals, and mission vision. Quality Management Boards were formed to monitor accomplishment of Command goals.

10/95 Performance Improvement takes first steps towards a command Performance Improvement plan.

10/95 Naval Station Branch Clinic closes.

NOVEMBER

11/06/95 NAVHOSP staff volunteered their time and energy to assist E. A. Burns Elementary school students by doing maintenance around the school, performing morning colors, and assisting in educating students during Fire Prevention Week.

11/12/95 NAVHOSP personnel, working in cooperation with the 437th Airlift Wing, Charleston Air Force Base, performed a week long field exercise to test the Wing's readiness capability using the new C-17 Globemaster III aircraft.

11/30/95 NAVHOSP celebrated Native American Heritage Week with a cultural event featuring traditional food, artifacts, crafts, and jewelry.

11/31/95 NAVHOSP softball team captured the last softball league championship ever to play at Naval Station Charleston.

11/95 LTJG Moe was recognized as Young Dietitian of the Year by the Charleston-Trident Dietetic Association.

11/95 South Carolina Congressman James E. Clyburn toured NAVHOSP.

11/95 NAVHOSP's Nutrition Management and Health Promotion and Wellness Department assisted E. A. Burns Elementary school staff in preparing and serving a special Thanksgiving Dinner for the students and school staff.

DECEMBER

12/08/95 The Trident Area Community of Excellence recognized NAVHOSP with the 1995 Trident Area Team Quality Award for the following improvement teams: Conscious Sedation Workgroup, Primary Care Team Planning Group, and the Linen Process Action Team.

12/11/95 NAVHOSP undergoes Inspector General's inspection.

12/95 The Operating Room and the Anesthesia Department procured an automated drug dispensing system to streamline the dispensing and documentation process of controlled drugs.

12/95 NAVHOSP personnel from the Pharmacy and the Chaplains office held a Christmas Food Drive and collected over 100 pounds of canned food and fifty dollars in cash.

12/95 In a test of readiness, NAVHOSP staff participated in a mass casualty fire evacuation drill.

12/95 NAVHOSP personnel participated in a holiday door decorating contest.

12/95 NJROTC Cadets from Summerville High School visited NAVHOSP to learn more about Navy Medicine.

12/95 NAVHOSP sponsored the Annual Essay Contest at E. A. Burns Elementary School. The topic for the essays was; "If you could spend the day with anyone you wanted, who would it be, why, and what would you do?"

12/95 The Council of Garden Clubs of Greater Charleston donated over 100 Holiday Wreaths to NAVHOSP to be used for decorations during the holidays.

12/95 Members of the local Elks lodge visited NAVHOSP, bringing Santa Claus and gifts to patients and staff.

The following volunteers were chosen throughout the year as "Volunteer of the Quarter":

First Quarter - W. I. Plumb

Second Quarter - Ed Colley

Third Quarter - Tom Wood

Fourth Quarter - Betty Dyer

"Volunteer of the Year" - Cliff Lines

The following personnel were chosen as NAVHOSP "Sailor of the Year":

Senior Sailor of the Year - HM1(FMF) David E. Roberts

Junior Sailor of the Year - HN Leeyanna M. Gerbich

The following person was selected as Civilian Employee of the Year:

Ms. Rosa Smith - Alternate Healthcare

The following reports, briefings, and correspondence document the events, problems, and solutions that NAVHOSP encountered during 1995. This section includes material from the following person/departments and resources:

Commanding Officer

Various NAVHOSP Department Heads

NAVHOSP Southern Starship newspaper

City of Charleston Office of the Mayor

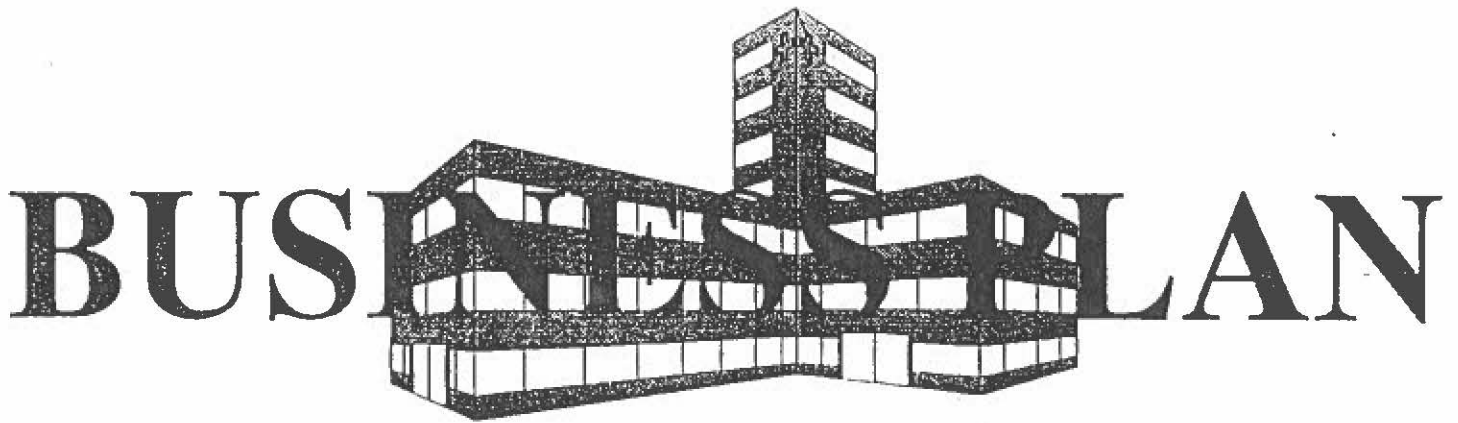
BUMED

Assistant Secretary of Defense

NAVHOSP Public Affairs Office

NAVHOSP Catchment Area Management Office

Naval Hospital
Charleston, SC



May 1995

ACKNOWLEDGEMENTS

This plan was developed and produced by the following individuals of the Market Analysis Department, Catchment Area Management (CAMS) Office, Naval Hospital, Charleston, South Carolina

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Velda Stewart, LT, MSC, USN
(Product Line Analysis Section)

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I. INTRODUCTION

This Business Plan for Naval Hospital, Charleston contains current data, as of May 1995, on our beneficiaries, military and civilian health care services available, Charleston area health care market assessment, military direct care and CHAMPUS expenditures, Base Realignment and Closure Commission (BRAC) impact on services, staffing, and demographics in the Charleston Catchment Area, TRICARE implementation issues and proposed enrollment plan, and finally, a comprehensive and detailed analysis, by product line, which compares costs, shows relative "profitability", and presents recommendations and other opportunities for improved efficiencies in how health care is purchased and delivered to eligible beneficiaries in Navy Military Treatment Facilities (MTF) in the Charleston area.

At the direction of the Commanding Officer, this plan was developed for functional use as a strategic planning document which will be updated, at a minimum, on an annual basis. This plan is to be considered as an ever changing document which is subject to constant input from factors both external and internal to Naval Hospital, Charleston. As Department of Defense, Bureau of Navy Medicine, and Lead Agent guidance changes on issues as wide ranging as military staffing, workload reporting, TRICARE implementation and related TRICARE Support Contractor activities, etc., this plan will change.

What is presented here for the very first time is thus a framework for future decision making and a response to the need for providing in writing and condensing into one easily found and referenced document, Charleston's current military and civilian health care environment and our vision, based on a product line methodology and analysis, for all future Navy MTF activities.

HISTORY

The roots of Naval Hospital, Charleston can be traced back to the year 1902 when hospital tents located near the site of the old Marine Corps Post Exchange housed the Medical Department activities. On June 29, 1906, Congress appropriated \$12,000 for a Naval Yard Dispensary which was finally completed in December 1908 by Navy Yard workers. Its meager beginning was a wooden building on a brick pier near the center of the Navy Yard.

The Naval Hospital, Charleston consisting of 19 temporary wooden buildings with a capacity of 250 beds was officially commissioned on 31 July, 1917. By the end of World War I, 14 additional buildings were constructed increasing the bed capacity to 1000 beds.

In the spring of 1941, construction was commenced on a 200 bed facility which was constructed on the site of the original temporary World War I hospital. World War II requirements necessitated the expansion of the hospital to 600 beds at the permanent structure now occupied by the Commander, Naval Base Charleston. In March 1973, the present hospital facility was completed and occupied.

HOSPITAL LOCATION

The Naval Hospital is located on the Charleston Peninsula, approximately 7 miles north of downtown Charleston. The Charleston Peninsula is formed by the Ashley River on the west and the Cooper River on the east. The Naval Hospital is located on the Cooper River (east) side of the peninsula, approximately 0.5 mile from the Charleston Naval Shipyard and Naval Station. The Naval Weapons Station in Goose Creek, approximately 12 miles north of the Naval Hospital, is also located on the Cooper River.

The Naval Hospital is situated in an area that can be best characterized as a declining area with a mix of mostly lower class residential housing, small businesses and malls, and other major industrial and shipping related activities. Demographics of the area show approximately 75% Black and 25% White by resident ethnic population distribution. The area surrounding the Naval Hospital is plagued by higher than normal rates of crime for the Charleston area.

Relatively good road and highway access to the Naval Hospital is provided by Interstate 26 at several exits and by surface streets; Spruill Avenue, Cosgrove Avenue, Dorchester Road and Rivers Avenue.

The Naval Shipyard Branch Clinic is about 0.5 mile from the Naval Hospital, the Naval Station Branch Clinic is about 2.8 miles from the Naval Hospital and the Naval Weapons Station Branch Clinic is about 9.5 miles from the Naval Hospital.

MISSION

Our mission is to keep the active duty members of all Armed Services healthy, and to provide health care to their families and other beneficiaries entrusted to our care.

VISION

Our vision is to be the model primary care community hospital in an integrated Department of Defense managed healthcare delivery system.

GUIDING PRINCIPLES

- * Customer service will be our primary focus in all decision making.
- * Recognize that our primary mission is to support combat readiness.
- * Manage the delivery of health care services, balancing access, quality, and cost containment.
- * Care for all persons as unique human beings worthy of our best professional efforts applied with courtesy, compassion, and respect.
- * Guard against inflexibility which interferes with meeting the needs of our customers.

NAVAL HOSPITAL CHARLESTON
KEY STAFF MEMBERS

COMMANDING OFFICER	CAPT H.B. Etienne, MC, USN
EXECUTIVE OFFICER	Col S. Langenberg, USAF, MSC
DIRECTOR FOR ADMINISTRATION	CDR S. Alford, MSC, USN
DIRECTOR FOR PATIENT SERVICES	CAPT E. Savige, NC, USN
DIRECTOR FOR CLINICAL SERVICES	CAPT J. Brown, MC, USN
DIRECTOR FOR MANAGED CARE	CDR M. Allard, NC, USN
COMPTROLLER	LCDR M. Bryson, MSC, USN

II. EXTERNAL ENVIRONMENT

GEOGRAPHY

The Charleston Metropolitan area is comprised of three counties, Berkeley, Charleston, and Dorchester that are located in a highly diverse market strategically located in the center of the Atlantic Coast. There are over 500,000 people in the region, with Berkeley and Dorchester counties leading the state in population growth. The area includes over ninety miles of Atlantic coastline along the central and southern South Carolina coast and reaches some fifty miles inland towards the intersection of Interstate 26 and 95. The greater Charleston area is also located in the Lowcountry section of South Carolina; so named due to the regional elevation relative to the Atlantic ocean. The Charleston Lowcountry hydrography is well defined by the abundance of river systems which give the Charleston peninsula its unique shape.

ECONOMY/POLITICAL

The greater Charleston area can best be currently described as having a stable, thriving economy encompassing a 2,600 square mile area mostly influenced by the Port of Charleston, a growing medical community, major tourism and seasonal visitor related industry, and national and international industry. The total civilian workforce is currently estimated at over 245,000 with government, services, wholesale and retail, and manufacturing industries employing the most people in that order. Recently published (April 1995) first quarter 1995 economic forecasts by the Tri-County Center for Business Research and Charleston Southern University show most of the key economic indicators pointing up, especially the overall growth of the employment sector.

The Charleston economy has been thriving despite the 1993 Base Realignment and Closure (BRAC) decision to close the Charleston Naval Base and Shipyard in 1996. However, certain economic indicators related to the area real estate market for low to middle income housing in selected residential areas remain soft. More recently, since January 1995, 14 ships and submarines have left Charleston further softening various service related industries (e.g. retail trade) due to the adverse effects of Navy families leaving the area.

DEMOGRAPHICS

Housing costs for the metropolitan area average \$ 114,610 with a median income level of \$32,114 and a median age of 30.2 years for area residents. Ethnic make-up is predominantly white at 67.8% of the total population of approximately 506,875 with African-Americans representing 30.2% and others representing 1.9% of this total. Population is projected to increase by 218,000 in fifteen years.

TRANSPORTATION

The Charleston Metropolitan area has excellent access to both the southeast and northeast due to its geographic position along major east-west (I-26) and north-south freeways (I-95). The area is also served by four major U.S. highways and seven major state highways. Interstate 526 (Mark Clark Expressway) is a nineteen mile freeway forming a semi-circle across the region stretching from U.S. Highway 17 (Savannah Highway) in the west, to U.S. Highway 17 in Mount Pleasant. The Port of Charleston is also the number one containerized port on the South Atlantic and Gulf Coasts, second only to the combined ports of New York and New Jersey, handling over million tons of cargo annually. The Norfolk-Southern, CSX System and the South Carolina Rail Road Commission also serve the region. The region's air service is provided by the Charleston International Airport, an international facility providing a unique combination of both commercial and military air service (Charleston Air Force Base) for the region.

Source information: Tri-County Chamber of Commerce, the Center for Business Research, Charleston Southern University, CAMS Office Research Files

III. COMPETITOR ANALYSIS

The following pages contain specific informational "snap shots" of the civilian health care institutions in the Charleston Catchment Area. Appendices in section III. contain comparative statistics on services offered, workload, capabilities, and market share for each "competitor" institution in the Charleston market.

Background and Philosophy of Competitors:

RALPH H. JOHNSON VETERANS AFFAIRS MEDICAL CENTER

The Ralph H. Johnson Veterans Affairs Medical Center is located at 109 Bee Street on the Charleston peninsula. The VA Medical Center is a primary, secondary and tertiary care institution which provides acute, medical, surgical and psychiatric inpatient care in addition to primary care and specialized outpatient services. The number of veterans in the Charleston VA service area is estimated at over 170,000. The VA is committed to providing compassionate, comprehensive health care that is responsive to the needs of the veteran. They are dedicated to being a leader in the advancement of health through research and education.

THE MEDICAL UNIVERSITY OF SOUTH CAROLINA HOSPITAL

The Medical University of South Carolina (MUSC) Hospital is located at 123 Calhoun Street on the peninsula. It is state owned and serves the citizens of the state and nation by providing primary, secondary, and tertiary care with a major trauma center. It prides itself as being South Carolina's leading provider of tertiary care. MUSC strives for eminence in areas of health education, patient services, and biomedical research. They recently entered a partnership with Trident Regional Health System, owned and operated by Columbia/HCA.

BON SECOURS-ST. FRANCIS XAVIER HOSPITAL

Bon Secours-Saint Francis is located at 135 Rutledge Avenue on the peninsula and is part of the Bon Secours Health System, Inc. and the healing ministry of the Roman Catholic Church. It strives to provide health care services to the people of Charleston and the surrounding Lowcountry, focusing its efforts on those whose health care needs are not being met. They believe they can accomplish this by always keeping in the mind the dignity of each person, by seeking creative solutions to the difficult problems, and by delivering quality health care in a values oriented and cost effective manner. In November of 1994, Bon Secours-St. Francis and the Medical Society Health System, the parent company of Charleston's Roper and Baker Hospitals, agreed to become partners by forming a joint development company called the Lowcountry Health System.

CHARLESTON MEMORIAL HOSPITAL

Charleston Memorial Hospital is located at 326 Calhoun Street on the downtown peninsula. It is a public, non-profit hospital that exists to provide quality health care services and programs in primary and specialty care to all citizens of the community regardless of their ability to pay. Charleston Memorial is closely affiliated with and is considered a part of the Medical University of South Carolina health care system. It is therefore committed to advancing the health status of the community and assisting in teaching and training of health care professionals for the Charleston community as well as the state of South Carolina.

CHARTER OF CHARLESTON

Charter of Charleston is a psychiatric and chemical dependency hospital located at 2777 Speissegger Drive in North Charleston. Its mission is to provide quality care for patients that are in need of psychiatric and chemical dependency treatment. It is an investor owned hospital that is part of the Charter Medical Corporation of Macon, Georgia. Charter Medical Corporation also recently acquired Fenwick Hall.

EAST COOPER COMMUNITY HOSPITAL

Located in Mount Pleasant across the Cooper River from peninsular Charleston, East Cooper Community Hospital serves the primary and secondary medical needs of the people in this area. AMI owns the 100-bed, acute care hospital which is currently under expansion; once completed will house 8 surgical suites, 13 labor/delivery/recovery suites and an expanded ER/ICCU area. The hospital is dedicated to providing quality and professional care with compassion and respect for all. With more than 270 physicians representing a variety of medical specialties and a full-time staff of approximately 400 employees, the location of East Cooper Community Hospital eliminates the need for residents of areas east of the Cooper River to drive downtown. The vision for the private, for-profit hospital is to be a leader in a fully integrated healthcare delivery system in the Lowcountry of South Carolina. It is currently under acquisition by National Medical Enterprises (NME).

TRIDENT REGIONAL HEALTH SYSTEM

Trident has established itself as a major health system in the Charleston area located in North Charleston. Under the management of Columbia/HCA, Trident offers comprehensive services to people in the northern region of Charleston. Trident Regional Health System is a provider whose mission is to offer services that meet the needs and exceed the expectations of patients, physicians, employees, employers and the community. The health system seeks to add value, reduce costs and improve benefits through a process of continuous improvement. The vision of

Trident is to set the community standard for comprehensiveness, innovation and excellence at the best value to the customer. Trident Regional, an acute, private, for-profit hospital, is presently developing a partnership with MUSC.

ROPER NORTH (BAKER) HOSPITAL

Originally built downtown in 1912, the Baker campus moved to North Charleston in 1981. Baker Hospital is an acute, private, not for profit hospital that prides itself with its closeness to the community and the family atmosphere that it promotes. It also considers mental health care to be one of its strengths with 44 alcohol and drug abuse beds. Baker is undergoing new alignment and will become part of the Lowcountry Health System with Roper and St. Francis Hospitals. Baker was acquired by Roper Hospital in 1994 and changed its name in early 1995 to Roper North Hospital. The Hospital strives to provide health care services of optimal quality and value to the people of the South Carolina Lowcountry. Some of the values that employees of the Hospital want to maintain for their customers include cleanliness, trust, quality, and safety. The main goal for the Hospital is to have a quality healthcare facility which will deliver quality healthcare for the surrounding community.

ROPER HOSPITAL

In the last decade Roper Hospital has adopted the hub and spoke concept of healthcare delivery. The hub represents the downtown campus and Roper's satellite facilities serve as the spokes. The first to introduce freestanding diagnostic centers, Roper has open seven of these facilities since 1985. Roper has joined Baker and St. Francis to form a Lowcountry Health System. Baker and Roper, the previous two remaining not-for-profit, locally owned hospitals in the community, have decided to merge. To help eliminate costly duplication of services, Roper Hospital is actively exploring new opportunities for working relationships with physicians and other healthcare providers in the Lowcountry region. Roper operates under the philosophy that it treats their patients as family, the community as partners, co-workers as friends, and the hospital as a home.

FENWICK HALL

Fenwick Hall is a psychiatric and chemical dependency hospital located on Johns Island, approximately 5 miles from downtown Charleston. In November 1994, Charter Medical Corporation purchased Fenwick Hall. Due its close proximity with an existing Charter facility, Fenwick Hall is expected to close in the near future.

MARKET ANALYSIS

HOSPITALS: By Bed Type

Institution	Med/S	OB Beds	Peds Beds	Rehab Beds	Other Beds	Total Beds (Institution)
AMI East Cooper	100	0	0	0	0	100
Roper North (Baker)	60	0	0	44	0	104
Bon Secours	169	20	6	0	24	199
Charleston Memorial	157	0	0	15	0	172
Charter of Charleston	0	0	0	70	32	102
Fenwick Hall	0	0	0	49	0	49
MUSC	466	66	79	81	0	547
Ralph Johnson VA	158	0	0	68	9	235
Roper Hospital	376	30	15	28	0	449
Trident Regional	231	20	10	20	0	281
Total Physicians (by category)	1,792	86	85	375	65	2,198

Source: MUSC Student Interns - Navy CAMS Office Project

PHYSICIAN NUMBERS: By Hospital Privilege Type

Institution	Act.	Asoc.	Courtesy/ Consult.	Honor.	Inact.	Total Physicians (by institution)
AMI East Cooper	101	0	0	0	0	101
Roper North (Baker)	45	25	206	0	0	276
Bon Secours	362	0	255	6	0	623
Charleston Memorial	328	0	0	0	0	328
Charter of Charleston	NA	0	0	0	0	0
Fenwick Hall	NA	0	0	0	0	0
MUSC	862	176	0	0	0	1,038
Ralph Johnson VA	400	0	0	0	0	400
Roper Hospital	710	63	0	0	0	773
Trident Regional	224	21	97	0	0	342
Total Physicians (by category)	3,032	285	558	6	0	3,881

Key: Act.= Active; Asoc.= Associate; Courtesy/Consult. = Courtesy/Consultative;
Honor.= Honorary; Inact.= Inactive

Source: MUSC Student Interns - Navy CAMS Office Project

HOSPITALS: By Type of Service Offered

Med. Svcs:	AMI	ROP (BAK)	BON	CHS	CHR	FEN	MUSC	VA	ROP	TRI
Ambul Svcs										
Phys Svcs	✓	✓	✓	✓			✓		✓	✓
Home Health Care		✓	✓						✓	✓
Diagn. Ref. Lab			✓				✓		✓	✓
Urgent Care	✓	✓	✓	✓	✓		✓		✓	✓
Ambul Srg. Unit		✓	✓	✓			✓		✓	✓
Pharm			✓				✓	✓		
Occp. Med		✓	✓				✓			
Phys. Therpy Ctr.	✓	✓	✓	✓			✓	✓	✓	✓
Vision Care							✓			
Gen. Acute Care										
Med/S	✓	✓	✓	✓			✓	✓	✓	✓
Obstet			✓	✓			✓		✓	✓
Peds.			✓				✓		✓	✓

Med. Srvcs:	AMI	ROP (BAK)	BON	CHS	CHR	FEN	MUSC	VA	ROP	TRI
ICU	✓	✓	✓	✓			✓	✓	✓	✓
CCU	✓	✓	✓	✓			✓		✓	✓
Peds. ICU							✓			
Tert. Srvcs							✓			
Cardio Cath.			✓				✓	✓	✓	✓
Cardio Srg							✓	✓	✓	✓
Neont ICU			✓				✓			
Onc/ Rad. Thrpy							✓	✓	✓	✓
Burn Care							✓			
Inpt. Dialys.			✓				✓		✓	✓
MRI	✓	✓	✓	✓			✓		✓	✓
CT Scan	✓	✓	✓	✓			✓		✓	✓
Traum			✓				✓		✓	✓
Spec. Inpt.							✓			
Subst. Abuse		✓			✓	✓	✓			
Phys. Rehab	✓		✓	✓			✓	✓	✓	✓

Med. Srvcs:	AMI	ROP (BAK)	BON	CHS	CHR	FEN	MUSC	VA	ROP	TRI
Psych.		✓	✓	✓	✓	✓	✓	✓	✓	✓
Long Term Care										
SNF/ICF			✓					✓	✓	
Long Term Psych					✓	✓	✓			
Nrsg Home									✓	✓

✓ = Service Offered

Key: AMI=East Cooper; ROP (BAK)=Roper North; BON=Bon Secours/St. Francis; CHS=Charleston Memorial; CHR=Charter Hospital; FEN=Fenwick Hall; MUSC=Medical University of South Carolina; VA=Ralph Johnson VA; ROP=Roper Hospital; TRI=Trident Regional Med. Ctr.

Source: MUSC Student Interns - Navy CAMS Office Project

HOSPITALS: General Information

	AMI	BAK	BON	CHS	CHR	FEN	MSC	VA	ROP	TRI
Type	M/S	M/S	M/S	M/S Psy	Psy/ Rehb	Psy/ Rehb	Tert. Psy	M/S Psy	M/S	M/S Psy
ER	Lv. 3	Lv. 3	Lv. 2	Lv. 2	None	None	Tr.-1	None	Tr.-3 Lv. 2	Tr.-3 Lv. 3
Stat.	Priv.	Priv.	Priv.	Co.	Priv.	Priv.	State	Fed.	Priv.	Priv.
Own. type	Invest	NFP	Chrch	Co.	Invest	Invest	Govt	Govt	NFP	Invest
Own. by	AMI	Roper	Bon Sec.	Chas.	Chart.	Chart.	SC	Govt.	Roper	HCA
Year Open	1986	1981	1882	1953	1987	1980	1824	1966	1850	1975
JC Accd.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Srvs Area (Co.)	Berk Chas Dorch	Berk Chas Colltn Dorch Geor Hamp	Berk Chas Dorch	Chas Berk Dorch	Allen Berk Beauf Chas Colltn Dorch Geor Hamp Horry	Allen Beauf Chas. Colltn Geor Hamp	All of SC	East. SC to East. GA	Berk Chas Colltn Dorch Geor Hamp	Berk Chas Colltn Dorch Geor Hamp
Total Inpt. Surg.	916	803	3515	1137	0	0	6984	1814	7838	NA
Total Outpt Surg.	2194	1621	6783	455	0	0	5594	314	5548	NA
Total Admt	3410	1853	7276	4199	1295	697	23 k	5853	15750	1196 1

	AMI	BAK	BON	CHS	CHR	FEN	MSC	VA	ROP	TRI
Avg LOS	4.6	10.7	6.26	6.6	17.3	16.2	8.5	10.2	6.9	6.3
Occp Rate (%)	42.9	52.1	66.5	44.2	59.9	63.6	72.1	69.5	71.5	68.1
Avg Daily Cens	45	58	124	100	53	38	480	163	296	219
Top Five DRG	127 089 088 416 014	127 437 014 089 088	127 430 014 296 088	430 127 014 296 088	430 429 428 426 425	NA	430 112 106 127 124	NA	127 014 209 410 296	127 014 089 296 088

Key: AMI=East Cooper; ROP (BAK)=Roper North; BON=Bon Secours/St. Francis;
 CHS=Charleston Memorial; CHR=Charter Hospital; FEN=Fenwick Hall;
 MSC=Medical University of South Carolina; VA=Ralph Johnson VA;
 ROP=Roper Hospital; TRI=Trident Regional Med. Ctr.

Source: MUSC Student Interns - Navy CAMS Office Project

HOSPITALS: Naval Hospital and CAMCHAS Network Relationship

Facility Name	Owner	Distance(1)	Drive Time(1)	Relationship
VA Medical Center	VA/Govt.	6.4	10 mins.	DoD/VA MOU in effect
Charleston Memorial	County	6.5	10 mins.	CAMCHAS
East Cooper	AMI	8	20 mins.	CAMCHAS
Fenwick Hall	Charter	9.8	20 mins.	CAMCHAS
Trident Regional Medical Center	HCA / Columbia	9.7	20 mins.	CAMCHAS(2) + External Partner for: Urol. Litho. OB Delivery, OB Nursery, OB/GYN
St. Francis/ Bon Secours	Catholic Church	6.5	10 mins.	CAMCHAS
Roper North (Baker)	Community	2.1	5 mins.	CAMCHAS
Roper	Community	6.5	10 mins.	CAMCHAS

Notes:

- (1) Drive time and distance as measured from Naval Hospital Charleston
- (2) Trident Regional Medical Center's Emergency Room (contract providers) is not part of the CAMCHAS network

PPOs: In the Charleston Market

	Health Care Savings	Private Health Care Systems	Ethix Southeast	USA Health Network	Focus Health Care Mgmt	Medcost
Model Type:	PPO	PPO	PPO	PPO	PPO	PPO
Physicians: # Primary # Specialty # Total	280 1120 1400	66 214 280	NA NA 2500	39 111 150	60 173 233	57 96 153
Hospital Membership # Acute Care # Psych/Rehab # Other Total	22 2 0 24	NA	0 0 0 34	NA NA NA 15	NA	NA

	Health Care Savings	Private Health Care Systems	Ethix Southeast	USA Health Network	Focus Health Care Mgmt	Medcost
Services Provided:						
Med/Surg	Yes	Yes	Yes	Yes	No	Yes
Dental	No	No	No	Yes	No	No
Vision	No	No	No	Yes	No	No
Psych	Yes	No	Yes	Yes	No	Yes
Rehab	Yes	No	Yes	Yes	No	No
Rx Drugs	Yes	No	No	Yes	No	Yes
Occ Health	No	No	Yes	Yes	No	Yes
Total Members	48,500	NA	NA	NA	NA	386,000 (U.S.)
Initial Year of Operation	1983	1993	1987	1986	1984	1984
Headquarters (State)	NC	MASS	NC	TENN	TENN	NC
Regions Served	All Metro Areas	State Wide	State Wide	All Metro Areas	State Wide	State Wide

Source: MUSC Student Interns - Navy CAMS Office Project

HMOs: In the Charleston Market

	Physician's Health Plan of SC	Companion Health Care (1)	HealthSource of South Carolina
ModelType (Staff/IPA, etc.)	IPA	IPA	IPA
Physician Membership # Primary Care # Specialty # Total	469 320 729	447 1103 1550	NA NA 3000
Hospital Membership: # Acute Care # Psych/Rehab # Other # Total	NA NA NA 21	NA NA NA 42	66 4 0 70
Services Provided: Med/Surg Dental Vision Psych. Rehab. Rx Drugs Occ. Health	NA NA NA NA NA NA NA	NA NA NA NA NA NA NA	Yes Yes Yes Yes Yes Yes No
Total Members	32,000	80,000	96,000
Total Assets	NA	NA	\$36.8 mil.

	Physician's Health Plan of SC	Companion Health Care (1)	HealthSource of South Carolina
Net Income (Year to Date)	NA	NA	\$4.4 mil.
Initial Year of Operation	1984	1984	1987
Headquarters (Location)	Columbia, SC	Columbia, SC	Charleston, SC
Regions Served (Counties, etc.)	All of South Carolina	All of South Carolina	All of South Carolina

Notes: (1) Companion Health Care HMO is owned and operated by Blue Cross and Blue Shield of South Carolina which has also recently launched another HMO in South Carolina with a local market presence called HMO Blue. There are no data available on Charleston's newest HMO due to its early 1995 operational start date.

Source: MUSC Student Interns - Navy CAMS Office Project

IV. MTF INTERNAL ENVIRONMENT

DEMOGRAPHICS

By analyzing current and projected population figures, according to age and gender, it is easy to detect various beneficiary/user trends. As a result of BRAC 93 decisions and the expectations that families of those military personnel transferred elsewhere will also move out of the Charleston area, the figures for all projections through FY 1999 indicate that this population's age/gender groupings of mostly younger active duty members and their families are expected to decrease steadily over the same time periods. However, as this younger population leaves the Charleston Catchment Area, the population of males and females over the age of 65 is expected to steadily increase.

While not surprising anyone, according to the Navy afloat component of active duty and their families, the entire population making up this category is going to show the greatest losses over the next few years. Dramatic decreases in the number of active duty afloat and families will occur by the end of FY 1996.

According to reports on utilization of primary care services, there are certain age groups that utilize these services more frequently than other age groups. For example, The retired population and their families utilize internal medicine more than any other subset of the total beneficiary population. The greatest overall utilization trends are seen in the male retired population ages 45 to 64. This group's use of internal medicine services is about twice that of any other category. The same population also utilizes general surgery services more than any other subset of the total beneficiary population.

Refer to appendices in section IV. for graphic representation of beneficiary population demographics in the Charleston Catchment Area.

EFFECTS OF BRAC 93 & 95

Still Open for Business!

The Naval Hospital Charleston was not placed under consideration for closure or realignment by BRAC 95. This decision means that Naval Hospital Charleston will remain open to provide medical care to its eligible beneficiary population.

New Naval Installations?

There are several DOD proposals, also included as part of BRAC 95, to move the Navy Nuclear Power Propulsion Training Center from Orlando, Florida. As of May 1995, both Charleston Naval Weapons Station and a site at New London, Connecticut are being seriously considered for this move. Orlando, Florida is also fighting very hard to keep this command activity at home. If Charleston were to gain this command, it would bring an additional estimated 500 staff instructors and approximately 2,500 active duty students to the area. The impact on increased demand utilization of services at Navy MTFs in Charleston is unknown at this time.

Naval Station Branch Medical Clinic

As a result of BRAC 93, the Naval Station Branch Medical Clinic is scheduled to close in August 1995. The clinic serves as a primary care site for fleet and shore based active duty sailors.

Charleston Naval Shipyard Branch Medical Clinic

Due to BRAC 93, the Charleston Naval Shipyard Branch Medical Clinic is scheduled to close in August 1995. The clinic primarily serves as an occupational health and industrial hygiene site for civilian employees of the Shipyard and Naval Station.

Naval Hospital Charleston

BRAC 93 adjusted population figures indicate that the number of active duty personnel within the Charleston Catchment Area will be reduced to approximately 12,765 members (average for year) by September 1995. It is estimated there will be an additional 61,652 (average for year) family members and retirees remaining in the Charleston Catchment Area. By September 1996, these numbers will drop to 8,368 and 64,012 respectively. By the end of FY 97, the total number of beneficiaries, including active duty personnel, is projected to drop to 61,897.

BUMED discontinued the Naval Hospital as a training site for Family Practice physicians and interns. As a result of the reduction in the active duty population, the Naval Hospital Charleston will build-down from its current 90 bed status to a facility of between 40 and 65 beds (depending upon final BUMED decision) and change its scope of available clinical services. Each clinical service that is currently offered will be evaluated for continuation, based upon several factors which include: economic viability, efficiency, necessity to support the primary mission (operational readiness), availability of services within the community. Due to limitations on the number and requirements for specialty providers, some clinics may be consolidated and/or restructured to achieve maximum efficiency. With few exceptions (noted below) this analysis is ongoing and specific details are not yet available.

Reduction of Hospital Staff

The Naval Hospital Charleston currently has authorization for 225 officer, 487 enlisted and 471 civilians staff positions. Due to the reduction of the hospital operating budget, the Naval Hospital has developed a plan to reduce staff position authorizations to 136 officers, 244 enlisted and 374 civilians by September 1995. This staff reduction plan is presently being executed.

Inpatient OB and Newborn Nursery

Naval Hospital Charleston stopped providing in house Obstetrical care and Newborn Nursery care on 01 October 1994. The hospital replaced its inhouse services with a more cost effective External Partnership agreement with Trident Regional Medical Center for these services. Under this partnership agreement military providers will continue to provide the professional services, and the civilian partner will provide the facility and ancillary services.

Inpatient Mental Health

The Naval Hospital Charleston will continue to provide outpatient mental health services to active duty military members. These services are offered on a space available basis to family members and retirees. The hospital has an External Partnership agreement with the Ralph Johnson Veterans Administration Medical Center in downtown Charleston to provide inpatient mental health services. Under this partnership agreement military providers will continue to provide the professional services, and the civilian partner will provide the facility and ancillary services. As the fleet leaves the Charleston area, the requirement for local inpatient mental health

services for active duty members will diminish significantly. The inpatient services are geared to assist the active duty member to return to full duty as soon as possible. The delivery of inpatient mental health services and the personal needs of the patient differs extensively between active duty military and family members.

Health Care Delivery Teams

The organizational structure of Naval Hospital Charleston has traditionally been based on the medical specialties available through uniformed providers. As the hospital builds down and the delivery of health care becomes more expensive, a more multi-disciplinary approach to delivering health care is required. On 01 October 1994, the Naval Hospital implemented three health care delivery teams which are comprised of physicians and health care workers trained in Family Practice, Pediatrics, Obstetrics/Gynecology, Surgery, Internal Medicine, Nursing, health care administration and other health related fields. Beneficiaries are able to receive their primary medical care from their assigned Health Care Delivery Team. This team approach will increase the emphasis on primary care and will be better able to direct the beneficiaries to specialty medical care when needed.

Primary Care Clinic

Prior to November 1994, the Naval Hospital had an Acute Care Clinic (ACC) under contract to a civilian contractor to provide acute medical care on an appointment and space available walk-in basis. This clinic was best suited to provide care for single episodic acute events, and was not designed to provide primary care to beneficiaries on a multiple episode of care or multiple medical problem basis. To assist the patients in having another avenue of obtaining primary care on a multiple episode of care basis, the Naval Hospital converted the ACC contract to a Primary Care Clinic (PCC) contract.

The new PCC contract has several features designed by its managed care staff which are considered unique in both Navy and DOD health care for similarly contracted primary care services: offering empanelment to patients to five primary care provider panels with options to increase purchase of additional panels if demand increases; and use of a modified form of capitation whereby the contractor is placed at risk and reimbursed on the total empaneled population's health care needs using optimal provider to total empaneled ratios. The PCC contract thus eliminates the traditional fee-per-visit reimbursement method and its typical non-managed care

philosophy which pays contractors more money to perform more services or to see more patients.

Empanelment of beneficiaries

To assist patients in obtaining easier access to primary medical care services, the Naval Hospital is offering an opportunity for beneficiaries to become assigned to a primary care manager (PCM). The PCM will act as a gatekeeper to provide the primary and specialty medical care needs of the patient. Once the patient has been assigned to a PCM, they will be required to contact their PCM prior to receiving any primary or specialty medical care. The PCM will provide assistance to the patients in obtaining the appropriate level of care.

Navy MTF empanelment is currently offered on Teams Gold, Red, Blue, and PCC (Team Green) at Naval Hospital, and to the MENRIV Branch Medical Clinic, Naval Weapons Station. The 437th Medical Group, Charleston Air Force Base is planning to begin its empanelment process in mid-1995. The empanelment process is designed to give beneficiaries consistency in obtaining medical care and easier access to medical care. Beneficiaries will still be able to use the Naval Hospital Emergency Room, NAVCARE, and the CAMCHAS preferred provider network regardless of their empanelment site.

STAFFING

NAVAL HOSPITAL MILITARY STAFF

	MC	DC	NC	MSC	ENL
BILLETS	76	2	110	42	466
ONBOARD	67	2	95	32	452
INPATIENT CARE	58	2	68	1	68
AMBULATORY CARE			19	5	112
ANCILLARY(SUPPORT)	7			7	95
OTHER ROLE	2		8	19	177

KEY:

BILLETS = BILLETS AUTHORIZED

ONBOARD = ONBOARD NUMBERS AS OF 14 FEB 95

ANCILLARY = NUMBER OF PERSONNEL ASSIGNED TO SUPPORT OR
(SUPPORT) ANCILLARY FUNCTIONS (E.G. LAB, X-RAY, ETC.
PHARMACY, SOCIAL WORK, NUCLEAR MEDICINE.

OTHER ROLE = CIVIL ENGINEER, LEGAL, CHAPLAIN, LINE
OFFICER ASSGN TO NH, ADMIN, STAFF ED,
OTHER OFFICER=6 BILLETS AUTHORIZED/4
ONBOARD.

NAVAL HOSPITAL CIVIL SERVICE STAFF

	Drs	RNs	LPNs	Pas	OTHs
BILLETS	3	36	40		385
ONBOARD		18	27		342
INPATIENT CARE		14	14		20
AMBULATORY CARE		4	13		1
ANCILLARY (SUPPORT)					37
OTHER ROLE					276

KEY:

BILLETS = BILLETS AUTHORIZED

ONBOARD = ONBOARD NUMBERS AS OF 14 FEB 95

OTHER ROLE = NUMBER ASSIGNED AND DESCRIBE THESE OTHER ROLES. ADMINISTRATIVE SUPPORT, FOOD SERVICE, HOUSEKEEPING, SECURITY.

CURRENT HOSPITAL CLINICAL PROVIDERS

SOURCE OF PROVIDERS

	MILITARY BA / OB	FTE CRT	FTE PTR	CIVIL SERV	RESV
CO/XO	02/02				
INTERNAL MED	08/04		.25		
NEUROLOGY	01/00				
DERMATOLOGY	02/03				
MENTAL HLTH	04/04			1	
EMERG MED	01/01				
PEDIATRICS	09/06				
FAMILY PRACTICE	13/07			1	
ARS	01/00				
GENERAL SURGERY	07/07				
ORTHOPEDICS	08/05				
OB/GYN	07/06		2.0		
OPHTHALMOLOGY	03/03		0.1		
OPTOMETRY	05/02				
UROLOGY	02/02				
OTOLARYNGOLOGY	03/02				
ANESTHESIOLOGY	10/11				
DENTAL	02/02				
LABORATORY	04/03				
PT/OT	01/01				
RADIOLOGY	04/04		1.0		
NAVCARE (CONTRACT)		19			
EMAC (CONTRACT)		25			

KEY: CRT=Contract, PTR=Partnership,

BRANCH CLINIC STAFFING (OCC HEALTH/SHIPYARD)

	BA	OB	PROVIDER	ANCILLARY	OTHER
MC	0	2	2		
GS MD/DO	2	2	2		
DC	0	0	0		
NC	0	0	0		
GS RN	3	2	2		
GS LPN	3	2	2		
PA	1	0	0		
OTHER MSC PROVIDER	0	1	1		
OTHER MSC	0	5	0		
HM	0	20	0	18	2
DT	0	0	0		
OTHER GS	23	23	2		21
OTHER	0	0	0		

BRANCH CLINIC STAFFING (NAVAL WEAPONS STATION)

	BA	OB	PROVIDER	ANCILLARY	OTHER
MC	0	3	3		
GS MD/DO	0	0	0		
DC	0	0	0		
NC	0	1	1		
GS RN	0	0	0		
GS LPN	4	0	4		
PA	0	0	0		
OTHER MSC PROVIDER	0	0	0		
OTHER MSC	0	0	0		
HM	0	25	0	25	
DT	0	0	0		
OTHER GS	5	5	1		4
OTHER *	6	4.5	3.5		

* MOU Partnership in effect with SPECTRUM, INC. to provide Family Practice providers, PA, and receptionist support staff.

BRANCH CLINIC STAFFING (NAVAL STATION)

	BA	OB	PROVIDER	ANCILLARY	OTHER
MC	0	0	1		
GS MD/DO	0	0	0		
DC	0	0	0		
NC	0	0	0		
GS RN	0	0	0		
GS LPN	0	0	0		
PA	0	2	2		
OTHER MSC PROVIDER	0	4	4		
OTHER MSC	0	0	0		
HM	0	42	0	42	
DT	0	0	0		
OTHER GS	2	2	0		2
OTHER	0	0	0		

HOSPITAL CAPABILITIES

NAVAL HOSPITAL - Inventory of Space/Beds

1. Number of beds routinely currently in use 57
2. Number of additional beds which could be supported (with ONHAND supplies, equipment, bed units, personnel, etc.) 70
3. Can BED SPACES be reconfigured for:
 - a. More efficiency (yes/no) NO
 - b. Expansion of work-units (yes/no) NO
4. Is there any vacant space?
 - a. Within the hospital buildings? YES
 - b. Adjacent land? NO
 - c. Explain: As of 2/95 there is approx. 13,000 sq.ft. of vacant space in the hospital. However, by 10/95, this space will be occupied as a result of closure of Naval Station/Shipyard Branch Clinics due to BRAC III decision to close Charleston Naval Station and Shipyard. There is no vacant land adjacent to hospital.
5. Can existing spaces be reconfigured for:
 - a.-More efficiency (yes/no) YES
 - b. Expansion of work-units (yes/no) NO
6. Number of outpatient exam rooms 87
 - a. List clinical departments which have

outpatient clinics and space (number of rooms)
assigned to each:

Group Practice Clinics	137
Orthopedic Clinic	24
Emergency Room (contract)	24
Ophthalmology Clinic	18
Primary Care Center (contract)	21
Dental Clinic	18
Mental Health Clinic	16
Urology Clinic	15
Dermatology Clinic	14
Otorhinolaryngology Clinic	14
Ambulatory Procedures Dept.	38

b. Could outpatient spaces be reconfigured for:

- (1) More efficiency (yes/no) YES
- (2) Expanded work-units (yes/no) NO
- (3) Explain: Outpatient spaces were designed and built for a simpler practice of medicine nearly 25 years ago. Reconfiguration would aid patient flow and efficiency. Outpatient clinics were established in areas designed for inpatient services. Changes would increase efficiency.

- 7. Number of operating rooms 7
 - a. Number in use per weekday 3-6
 - b. Number in use per weekend day 0-1
 - c. Hours per day each is in use 8
 - d. Number not used for surgery 0
 - e. Do you do ambulatory surgery? Yes
- Describe the spaces: 7 bed open bay ward.
- Could this be expanded? No

Explain: Expansion would require relocating to other spaces off of the OR suite area.

8. Recovery room capabilities.

- | | |
|---|-----|
| a. Number of patient spaces available | 7 |
| b. Number of spaces used each weekday | 6-7 |
| c. Number of spaces used each weekend day | 0-1 |

NAVAL HOSPITAL - Inpatient Capabilities

Ward 7A	Multi-service Medical/Surgical ward 42 available beds (expandable total - not staffed for 42 beds) 15 average Occupied Beds/Day (1/94-1/95 MEPRS) Prior to 10/94, a second Med/Surg ward existed
Ward 6A	Pediatrics 24 available beds (expandable total - not staffed for 24) 3 average Occupied Beds/Day (1/94-1/95 MEPRS)
ICU	10 available beds (includes 4 telemetry beds) 4 average Occupied Beds/Day (1/94-1/95 MEPRS)

There are no inpatient labor beds, delivery beds, inpatient mental health beds or recovery beds at Naval Hospital Charleston. All inpatient services for Obstetrics are performed by Trident Regional Medical Center under the External Partnership Program. Inpatient mental health services are delivered by the VA through an External Partnership equivalent to an existing DOD/VA Resource Sharing Agreement (military providers see and treat our active duty members at the VA facility). This MOU arrangement is with the Ralph Johnson VA Medical Center in downtown Charleston.

FACILITY MILCON/SPECIAL PROJECTS

CURRENT PROJECTS

		<u>COST</u>
P-061	EMERGENCY ROOM EXPANSION AND RELOCATION Completed 8/92. The project relocated the ER from north side to south side, increased size from 3,220 sq. ft. to 9,230 sq. ft. This allowed ER to more adequately handle increased volume of patients with better access and space for Group Practices (formerly Family Practice) to expand into space vacated by old ER location.	\$813K
P-939	LIFE SAFETY UPGRADE This project was initially programmed for FY91, then delayed until FY95 and after the BRAC 93 decision, was postponed until FY98. The project will correct numerous life safety deficiencies in electrical, mechanical, fire suppression, and water distribution, and upgrade the air conditioning and emergency power generators.	\$8.0M
P-834	BEQ IMPROVEMENTS The project was originally programmed for FY95 and was under design when it was dropped from the MILCON list during BRAC 93. It has not been re-programmed. The project would repair the BEQ's deteriorated structural, mechanical, and electrical systems.	\$2.2

SPECIAL PROJECTS

COMPLETED:

R2-89	REPAIR HOSPITAL ELEVATOR SYSTEM Completed 12/94. This project overhauled all elevators in the hospital.	\$474k
CER1-90	UROLOGY CLINIC RELOCATION Completed 5/92. This project provided more space for the Urology Clinic department and allowed the installation of modern medical equipment.	\$257K
CA1-90	HVAC IMPROVEMENTS Completed 2/95. This project upgraded the HVAC system for the Operating Rooms, Labor and Delivery, and Newborn Nursery.	\$170k

PLANNED PROJECTS

R4-89	REPLACE EXTERIOR WINDOWS This project would replace all exterior windows of the hospital. The leakage through and around the building represents a health and safety hazard for the patients and staff members.	\$1.4M
RC1-93	REPLACE LIQUID OXYGEN SYSTEM This project would replace the deteriorated liquid oxygen tank while providing an adequate and reliable back-up system.	\$124k

REFERRAL PATTERNS

When a patient comes to any Charleston area MTF (Air Force Base included) clinic or primary care group practice (including patient visits to NAVCARE) for medical care which requires a referral to a specialist, the following referral process action steps take place:

1. The referral is transmitted by CHCS terminal (automated consult feature) or hand carried to Health Care Finders (HCF). Referrals from outside providers are also sent to HCF.
2. HCF assigns tracking number and then sends the referral to the Naval Hospital specialty Department Head for review/action.
3. The Department Head has three (3) days turn around time to send decision back to HCF with disposition of either seeing the patient in Naval Hospital or referring patient to an outside provider. Referrals to outside providers are sent to CAMCHAS preferred network providers.
4. HCF contacts the patient based on referral status as follows:

IN-HOUSE REFERRAL - HCF makes appointment and gives pertinent information/answers questions.

CAMCHAS PPO - HCF asks patient what provider they would like to see for their medical problem. Patients have choice of over 900 providers in CAMCHAS PPO. HCF, using a three-way calling system, connects the patient with the provider office to set the referral appointment. HCF explains CHAMPUS benefits to patient and gives pertinent information/answers questions.

5. HCF records appointment in CHCS and either sends the referral to medical records, in-house provider, or sends it via mail/fax to the CAMCHAS provider.

SUPPLEMENTAL CARE EXPENDITURES

	FY 92	FY 93	FY 94
SUPP HLTH	\$ 1,108,234	1,437,116	1,141,764
PURCH HLTH	240,088	226,184	42,720
TOTALS	\$ 1,348,322	1,663,300	1,184,484

.(Source: NC 2171 for FYs 92,93,94)

PARTNERSHIPS/MOUs/CONTRACTS

ACTIVE EXTERNAL PARTNERSHIPS

Service	Provider	Start	End	Percent CMAC/DRG
Urological	Trident	Oct 94	Oct 96	85% 70 Cases per year
OB/GYN/Newborn				
Nursery/Peds		Sep 94	Oct 96	85% 480 Deliveries/year

Notes: Circumstances resulting in an admission revert to DRG payment, less the CAMCHAS percentage discount. Obstetrical patients receive prenatal care at MTF. Delivery and newborn care at partnership facility by MTF physicians.

DOD/VA RESOURCE SHARING AGREEMENT (EXTERNAL PARTNERSHIP MOU)

Although not considered as an "official" External Partnership Program, the DOD/VA Resource Sharing Agreement for inpatient mental health allows Naval Hospital Charleston psychiatrists full admitting privileges at the Charleston VA Medical Center to see active duty members. FY 95 estimated workload and MTF costs: 1000 OBD at \$269 per diem rate - estimated at \$269,000 annually (represents a "savings" of \$233,000 over Naval Hospital Charleston costs if done MTF in-house).

**MAJOR CONTRACT:
EMERGENCY ROOM SERVICES AND PRIMARY CARE CENTER ***

Contract Start date:
November 1994

Contract End date:
November 1997

Contractor:
EMSA Limited Partnership
Fort Lauderdale, FL

* Contract Specifics:

Purchase of five (5) initial provider panels (each panel consists of a Board Certified FP, with dedicated PA and admin/nurse support staff, etc.) for the delivery of total primary care services - featuring a triage based appointment system with same day/walk-in service - to a defined patient population assigned to each panel. Patients assigned to the PCC are not allowed to seek routine/non-urgent primary care services at any other MTF clinic. Contract has options which allow for the purchase of an additional six (6) panels, as needed. Contract replaced an Ambulatory Care Clinic which, despite offering some appointments, served mostly as an overflow clinic for non-acute ER patients.

Total Cost of Contract (if all options exercised and incentive awards rewarded at end of three years):
\$17.6 Million

* Note: For the Primary Care Center (PCC), Naval Hospital Charleston developed a unique contract reimbursement method using proven managed care techniques based on a fixed fee, modified form of capitation with limited risk - contractor is paid based on patients assigned (empaneled) and total care needs of a defined patient population assigned to PCC - using a range of empaneled patients to one provider panel (current ratio average approximately 1: 2,000). This reimbursement method eliminated the contract cost inflationary problems inherent with typical/traditional contractor payment based solely on per visit charges and/or step scale payments.

READINESS/CONTINGENCY

POMI - MOBILIZATION RESPONSIBILITIES:

Naval Hospital, Charleston (NHCHASN), utilizing the Medical Personnel Augmentation System (MPAS) module of the Standard Personnel Management System (SPMS), monitors the mobilization readiness of the 792 military personnel assigned to the command. Health Care Support Office (HCO), Jacksonville has assigned 16 mobilization platforms to be filled by this command. These platforms include: USMC elements, combatant ships, hospital ships, fleet hospitals, and overseas shore commands. Of the 772 platform billets assigned, we currently have 471 filled. The remaining 301 platform billets are listed as shortfalls due to a lack of NOBC/NEC matches with the billet requirements. Prior to actual mobilization, HCO or BUMED will provide platform shortfall info. with substitute command personnel. Command mobilization will proceed according to direction from higher authority based on the intensity of the conflict requiring mobilization. This may vary from the mobilization and deployment of one platform to the whole command deploying minus the cadre staff. The cadre staff are non-deployable members of the command comprising the POMI staff, Blood Donor Team, and essential command and TAR personnel to assist in the transition from an active duty to reserve staffed facility.

If mobilized, NHCHASN will implement Logistic Support Mobilization Plan (LSMP) to act as guideline for command mobilization. Instruction (NHCHASNINST 4812.1A) is a time phased reference that can be executed in its entirety or in part for military or national disasters under direction of the Commander, Naval Base, Charleston (COMNAVBASE), BUMED and higher authorities. It provides for: the mobilization, training, and deployment of staff members; the back-fill of deployed staff with reserve units; increased operational readiness; and expansion of medical capabilities.

READINESS/CONTINGENCY

DISASTER RESPONSIBILITIES:

1. MILITARY: NHCHASN functions as a Federal Coordinating Center (FCC) and as such is under the control and direction of USACOM, Norfolk via

COMNAVBASECHASN. When directed to do so this facility can coordinate the receipt, hospitalization, and medical regulating of war casualties in conjunction with the Charleston Air Force Base.

2. FEDERAL: As a Federal Coordinating Center (FCC) the Naval Hospital will work in conjunction with the COMNAVBASECHASN Regional Planning Agent (RPA) for appropriate disaster preparation and planning as directed by the USACOM, Norfolk Principal Planning Agent (PPA) who in turn is a representative of the Federal Emergency Management Agency (FEMA) or other federal disaster agency. NHCHASN in association with the regional Veteran Affairs Hospital also represents the National Disaster Medical System (NDMS) in all matters related to NDMS activity in the Charleston area.

3. LOCAL: In the event of a local disaster NHCHASN will be under the command and control of COMNAVBASECHASN and will work directly with local area hospitals, emergency services, and county emergency preparedness departments to render whatever aid is required. At the Commanding Officer's discretion various medical teams and the Mobile Medical Augmentation Readiness Team (MMART) may be dispatched (MMART responsibility at Naval Hospital Charleston will end 01 October 1995). If the severity of the local disaster warrants the assistance of federal disaster agencies, paragraph 2 will be initiated once the federal agency takes charge of the area.

STRATEGIC GOALS, OBJECTIVES, AND MEASUREMENTS

Strategic Goals, Objectives, and Measurements for Naval Hospital, Charleston have been reviewed, examined and further realigned by the Executive Support System (ESS) working group. The ESS working group's January 1995 progress report and update to the Executive Steering Committee (ESC) listing the changes recommended and performance measurements required follows:

GOAL 1: "WE WILL MAINTAIN OPERATIONAL READINESS"

- * Maintain 80% C-1/C-2 Status
- * Maintain 100% of Staff Medical and Dental Records in the MTF System with annual verification
- * 100% annual PRT pass rate for individuals meeting instructional requirements for participation

Initiatives: Implement policy for enhanced medical accessibility/availability for deployment imminent platforms, internal and external to the command.

GOAL 2: "WE WILL MAXIMIZE THE COORDINATION AND UTILIZATION OF RESOURCES"

- * Designated Billets filled by qualified/trained individuals
- * Full identification of Third Party Payors with a 80% collection rate
- * Annual reduction of hospital's operating costs as a ratio of command's capitated budget
- * Meet or beat national comparative benchmarks in Length of Stay for targeted Diagnostic Groups
- * Control CHAMPUS expenditures by expanding use of Contracts/Partnerships to decrease the number of Non-Availability Statements (NAS)
- * Monitor compliance of Partnerships and Contractual criteria

Initiatives: Implement activity based costing management system. Implement UM Program within 12 months with medical staff involvement in outcomes measures.

GOAL 3: "WE WILL MAXIMIZE THE DELIVERY OF HEALTH CARE"

- * Meet or exceed all DOD Active Duty health care indicators
- * 95% fill rate on all available appointments
- * Maximize utilization of an alternate care system for non-hospital skilled nursing care
- * Fully computerized inpatient records

Initiatives: Establish monthly health promotion community activities with an emphasis on new program development. Implement monthly target market coverage relating to community health promotions. Research, develop, and implement a computerized inpatient record system.

GOAL 4: "WE WILL PROMOTE JOB SATISFACTION THROUGH A POSITIVE WORK ENVIRONMENT"

- * Fulfill 90% job expectations based on survey results
- * Train all staff in TQL methods and concepts

Initiatives: Establish "Quality Bill of Rights". Use Navy Achievement Medal as recognition for "Sailor of the Quarter". Establish Meritorious Service Award as recognition for "Civilian of the Month". Select from "Civilian of the Month" winners for "Civilian of the Year" and present Superior Civilian Service Award as recognition.

GOAL 5: "WE WILL PROMOTE A POSITIVE COMMAND IMAGE"

- * Improve customer satisfaction base on survey results
- * Reduce deficiencies on zone inspections
- * Increase media coverage on hospital and staff successes

Initiatives: Implement standard survey instruments that capture customer satisfaction. Reinstitute zone inspections for the command with emphasis on safety, aesthetics, maintenance, and repair. Media blitz targeted populations about upcoming health promotion activities, then gather consumer information at activities to determine the most effective media channels for coverage of hospital activities.

GOAL 6: "WE WILL PROMOTE THE PROFESSIONAL DEVELOPMENT, EDUCATION AND TRAINING OF ALL HOSPITAL PERSONNEL"

- * Increase professional growth and advancement
- * All Time in Rate (TIR) eligible personnel will compete for advancement
- * Initial competency review of primary skills completed within 90 days of assignment and annual review thereafter

Initiatives: Develop a position skills list for all hospital positions. Develop a policy for review and accountability (using JCAHO standards) of competent skills.

GOAL 7: "WE WILL PROMOTE COMMUNITY WELLNESS"

- * Health Promotion Department will develop one new community activity per fiscal quarter.
- * We will increase our attendance per cost ratio on health screening activities.
- * We will market to 95% of our target beneficiaries annually.

PRODUCT LINE ANALYSIS

The following Product Line Analyses reveal the importance of ensuring that the services offered by Navy MTFs in Charleston continually meet the important criteria of cost, quality, and access.

PRODUCT LINE ANALYSIS FOR INPATIENT PRIMARY CARE SERVICES

CLINICAL SERVICES

Service	MEPRS Codes
Internal Medicine	AAA
Pediatrics	ADA, ADB
Family Practice	AGA, AGB, - AGC, AGD, AGE, AGH

COMPARISON OF COST DATA (FY 1994)

Service	MTF Expense	Estimated CHAMPUS Cost	Difference (MTF - CHAMPUS)
Internal Medicine	\$3,810,910	\$1,837,955	\$1,972,955
Pediatrics	\$2,340,464	\$1,833,808	\$ 506,656
Family Practice	\$1,448,809	\$2,027,077	(\$ 578,268)
Totals	\$7,600,183	\$5,698,840	\$1,901,343

FACTORS AFFECTING MEPRS EXPENSES

Family Practice Resident Training is included in the FY 1994 workload and cost data, which may indicate higher acuity levels, longer lengths of stay, and higher expenses than may be incurred in FY 1995 and beyond.

PATIENT UTILIZATION

Patients Utilizing Inpatient Primary Care Services						
Inpatient Service	Active Duty Pts	% of Svc Total	CHAMP Elig Pts	% of Svc Total	MEDI-CARE Elig	% of Svc Total
Int Med	159	21%	428	57%	165	22%
Pediatrics	0		296	100%	0	-
Fam Pract	92	21%	284	65%	61	14%

RAPS ELIGIBLE POPULATION PROJECTIONS

Based on the RAPS Projection Model, the composition of the eligible population in the Charleston Catchment Area will experience the following changes by FY 1997.

Beneficiary Category	FY 1994 , People	FY 1994 Percent	FY 1997 People	FY 1997 Percent
Active Duty	19,389	21.55%	7,566	12.22%
Dep Active Duty	35,176	39.10%	19,253	31.10%
Med Elig NG/Res	803	0.89%	714	1.15%
Dep of NG/Res	948	1.05%	837	1.35%
Retired	12,539	13.94%	12,483	20.17%
Dep Retired	18,218	20.25%	18,310	29.58%
Survivor	2,900	3.22%	2,734	4.42%
Totals	89,973	100%	61,897	100%

FUTURE COST AND SERVICE DELIVERY IMPACTS OF THE POPULATION TRENDS

As the Active Duty Sponsors and their families leave Charleston, due to BRAC decisions, a larger percentage of the available military health care resources will be consumed by Retirees and their family members. It is reasonable to expect that an even larger percentage of the inpatients will be Medicare eligible patients who will have higher acuity levels, multiple medical problems, and incur longer lengths of stay than have been experienced in the past.

CIVILIAN SECTOR, FEDERAL, TRI-SERVICE OR LEAD AGENT ISSUES

The civilian medical community in Charleston has an abundance of high quality, but under utilized, inpatient services with well established and well staffed medical delivery systems. The civilian sector could easily absorb the MTF's demand for inpatient Primary Care services - particularly those requiring the services of specialists such as cardiologists, pulmonologists, gastroenterologists, and neurologists. The Ralph Johnson VA Medical Center in Charleston is currently offering assistance in providing cardiology services; however administrative hurdles (CHAMPUS billing) must be overcome before this will become a fully viable option for all MHSS eligible beneficiaries.

OUTPATIENT MARKET SHARE

This will be addressed in the Product Line Analysis for Outpatient Primary Care Services.

INTERRELATIONSHIPS WITH GME OR OTHER CLINICAL SERVICES

The Family Practice Training Program ended in June 1994. At the time of this analysis the training activities in this facility are limited to training MUSC medical students, civilian surgical ENT & GYN training, and civilian nurse practitioner training. Efforts are underway to establish another Family Practice Training Program at this facility in the future.

MISSION UNIQUE OR READINESS RELATED ISSUES.

Any lengthy deployments of primary care providers will reduce the amount of care available and drive up the per unit cost of care, due to spreading out the same amount of fixed costs over lesser units of care.

RECOMMENDATIONS FOR FUTURE DELIVERY OF THIS PRODUCT LINE

Continue to provide Family Practice inpatient services without any changes.

Continue to provide Pediatric inpatient services for patients with low acuity levels, and explore the potential for using the existing CHAMPUS External Partnership with Trident Regional Medical Center.

Continue to provide Internal Medicine inpatient services for patients with low acuity levels. Also re-evaluate data after 1 year of performance without residents and specialists on board. Continue to forge ahead with arrangements for all Internal Medicine services provided by the VA Medical Center.

PRODUCT LINE ANALYSIS FOR
OUTPATIENT PRIMARY CARE SERVICES

CLINICAL SERVICES

Service	MEPRS Codes
Internal Medicine	BAA
Cardiology	BAC
Neurology	BAK
Pediatrics	BDA, BDC
Family Practice	BGA
Primary Care Clinics (PCC, NWS, Naval Sta)	BHA
Optometry	BHC
Emergency Medicine	BIA
Dental Services	CAA, CAB
Health Promotion	No MEPRS Code
NAVCARE	BHH

COMPARISON OF COST DATA (FY 1994)

Service	MTF Expense	Estimated CHAMPUS Cost	Difference (MTF - CHAMPUS)
Internal Medicine	\$2,272,726	\$924,945	\$1,347,781
Cardiology	0	0	0
Neurology	\$365,036	\$135,936	\$229,100
Pediatrics	\$1,258,125	\$1,367,775	(\$109,650)
Family Practice	\$4,525,119	\$4,499,216	\$25,903
Primary Care Clinics	\$5,567,695	\$5,444,938	\$122,757
Optometry	\$446,506	\$673,829	(\$227,323)
Emergency Medicine	\$7,906,361	\$2,845,477	\$5,060,884
Dental Service	\$544,736	Data Not Available	
Health Promotion	Data Not Available	Data Not Available	
NAVCARE	\$2,906,255	\$6,329,841	(\$3,423,586)
Totals	\$25,792,559	\$22,221,957	\$3,570,602

Cardiology services were provided in the MTF during FY 94, by a military cardiologist. The costs are included in the Internal Medicine data.

In FY 94, care at the Ambulatory Care Clinic was provided through a contractual arrangement with Spectrum, as were the Emergency Room services.

Data is not available for the Health Promotion Department, as a separate MEPRS code is not established for it.

The data displayed below shows the average cost per visit for each service, both in the MTF and through CHAMPUS.

Outpatient Service	MTF Avg Cost per Visit	CHAMPUS Avg Cost per Visit	Difference
Internal Medicine	232.05	94.44	137.61
Neurology	278.23	103.61	174.62
Pediatrics	86.87	94.44	(7.57)
Family Practice	94.98	94.44	0.54
Primary Care Clinics	96.57	94.44	2.13
Optometry	62.58	94.44	(31.86)
Emergency Medicine	262.64	94.44	(168.20)
NAVCARE	43.36	94.44	(51.08)

FACTORS AFFECTING MEPRS EXPENSES

Family Practice Resident Training is included in the FY 1994 workload and cost data, which may indicate higher acuity levels, longer patient visits, and higher expenses than may be incurred in FY 1995 and beyond.

patients that increase the cost of care in an HMO plan. Generally, they have more health care problems of increasing complexity. Subsequently, the frequency of visits, time needed in each visit, and greater use of ancillary services (particularly pharmacy) result in increased costs.

CIVILIAN SECTOR, FEDERAL, TRI-SERVICE OR LEAD AGENT ISSUES

The civilian medical community in Charleston has an abundance of high quality, outpatient services with well established and well staffed medical delivery systems. These services are utilized by MHSS beneficiaries when space is not available in the MTF. They are referred to the civilian providers via Health Care Finders, and receive a discount off the CHAMPUS Maximum Allowable Charges (CMAC) due to negotiated agreements established under the auspices of the CAMCHAS Demonstration Project.

OUTPATIENT MARKET SHARE

The FY 94 outpatient market share for those services where CHAMPUS data is obtainable from the FY 94 HCSR is displayed below. CHAMPUS visits for Internal Medicine services include all subspecialties within the Internal Medicine category, except Neurology.

Outpatient Service	MTF Visits	% of Mkt Share	CHAMPUS Visits	% of Mkt Share
Internal Med	9,794	19%	40,520	81%
Neurology	1,312	23%	4,351	77%
Pediatrics	14,483	95%	842	5%

The FY 94 breakdown by location for the remainder of the Primary Care Services is displayed below.

Outpatient Service	Naval Hospital	Weapons Station	Naval Station	Naval Shipyard
Family Practice	75%	25%		
Primary Care	68%	6%	26%	
Optometry		10%	84%	6%
Emergency Med	100%			
Dental Services	100%			
Health Prom	100%			

INTERRELATIONSHIPS WITH GME OR OTHER CLINICAL SERVICES

The Family Practice Training Program ended in June 1994. At the time of this analysis the training activities in this facility are limited to training MUSC medical students, civilian surgical ENT & GYN training, and civilian nurse practitioner training. Efforts are underway to establish another Family Practice Training Program at this facility in the future.

MISSION UNIQUE OR READINESS RELATED ISSUES

Any lengthy deployments of primary care providers will reduce the amount of care available and drive up the per unit cost of care, due to spreading out the same amount of fixed costs over lesser units of care.

RECOMMENDATIONS FOR FUTURE DELIVERY OF THIS PRODUCT LINE

Perform another Product Line Analysis after the end of FY 95 to assess how significantly workload and costs have changed due to the termination of the Family Practice training program, the loss of the military cardiologist and neurologist, the formation of the military group practices, and the new contractor (EMSA) providing Primary Care Center and Emergency Medicine services.

Continue to work with the NAVCARE clinic to improve access to care, continuity of care and administrative management of the care (i.e., referrals).

Focus on determining the causes of the perceived inefficiencies in the military group practices, and work toward resolution of the problems.

Collect CPT Code data for all outpatient visits in the MTF that shows what services were provided to the patient, as well as the CPT Codes for Evaluation & Management (99 series -- show if the patient is New or Established, and the length of the visit). Having this data available will allow for a comprehensive analysis to compare costs by CPT Code, and to determine the types of services actually provided to our beneficiary population.

PRODUCT LINE ANALYSIS FOR
INPATIENT SPECIALTY SUPPORT SERVICES

CLINICAL SERVICES

Service	MEPRS Codes
General Surgery	ABA
Ophthalmology	ABE
Oral Surgery	ABF
Otorhinolaryngology	ABG
Urology	ABK
Gynecology	ACA
Obstetrics	ACB
Orthopedics	AEA
Mental Health	AFA, AFB

COMPARISON OF COST DATA (FY 1994)

Service	MTF Expense	Estimated CHAMPUS Cost	Difference (MTF - CHAMPUS)
General Surgery	\$4,710,391	\$4,785,158	(\$74,767)
Ophthalmology	\$467,764	\$3,132,551	(\$2,664,787)
Oral Surgery	\$203,269	\$535,765	(\$332,496)
Otorhinolaryngology	\$1,231,329	\$4,920,697	(\$3,689,368)
Urology	\$1,284,488	\$1,245,416	\$39,072
Gynecology	\$1,603,971	\$2,649,860	(\$1,045,889)
Obstetrics	\$2,859,938	\$3,830,678	(\$970,740)
Orthopedics	\$4,975,380	\$4,515,051	\$460,329
Mental Health	\$1,464,050	\$1,675,116	(\$211,066)
Totals	\$18,800,580	\$27,290,292	(\$8,489,712)

FACTORS AFFECTING MEPRS EXPENSES

Obstetrics It appears that it is less expensive to perform OB services in the MTF than in the civilian community. This data is misleading because the CHAMPUS reimbursement for OB services is a global payment that includes antepartum care, delivery, and postpartum care. If the MTF expenses are calculated in the same fashion, the MTF becomes the more expensive option, as shown below:

MTF Inpatient Expenses (727 dispositions)	\$2,859,938
MTF Outpatient Expenses (13 visits per disposition at \$111.93 per visit -- \$1,455 per patient)	\$1,057,850
Total MTF Expense	\$3,917,788

Based on similar cost information for FY 93 and the projected decrease in the childbearing population in the Catchment Area, inpatient OB services were terminated on 01 October 1994. These services are now being delivered at Trident Regional Medical Center via an External Partnership arrangement.

Mental Health The significant drop in Active Duty patients requiring inpatient Mental Health services resulted in the termination of these services in January of 1995. These services are now provided to Active Duty patients at the VA Medical Center in Charleston, via a DOD/VA Resource Sharing Agreement. For similar reasons, inpatient Substance Abuse care was terminated in July of 1993. Active Duty patients requiring these services are now referred to other Navy facilities who provide the services.

Orthopedics The average cost per MTF disposition was \$6,714.41 in FY 94 (an increase of \$2,426.32 per disposition from FY 93). The average CHAMPUS cost per disposition (institutional & professional) was \$6,093. The average per disposition difference of \$621 accounts for the \$460,329 difference in the total cost of this service. Analysis of the FY 94 and FY 93 MEPRS data shows that 29 fewer patients were admitted in FY 94, but the Direct Expenses increased by \$94,477. The Support Expenses decreased by \$44,893, while Ancillary Expenses increased \$139,260 and the Purified Expenses increased by \$1,484,703 -- for a net gain of \$1,673,547 over

the FY 93 Total Expenses. An analysis of the top 3 DRGs in FY 94 and FY 93 (per RCMAS) indicates that the same procedures are being performed in relatively the same proportions, as shown below:

<u>DRG</u>	<u>FY 93</u>	<u>FY 94</u>
222 Knee Proc w/o CC	183	108
229 Hand or Wrist Proc, Exc Major Joint w/o CC	101	60
231 Local Excision & Removal of Int Fix Devices (Except Hip & Femur)	96	103

Urology In FY 94 the MTF cost per inpatient Urology disposition was \$3,302.03, as compared to the average CHAMPUS cost per inpatient Urology disposition of \$3,201.58 -- a difference of \$100.45 per disposition. Improvement appears to have been made in the MTF as the FY 94 cost per disposition is \$1,156 less than is was in FY 93. However, the MTF FY 94 cost per disposition is higher than the CHAMPUS cost per admission for the top 3 DRGs performed in the MTF which account for 27% of the total dispositions. The per disposition costs for the top 3 DRGs are as follows:

<u>DRG</u>	<u>MTF Avg Cost</u>	<u>CHAMPUS Avg Cost</u>	<u>Difference</u>
339 Testes Proc, Non-Malignant Age >17	\$3,302	\$2,600	\$ 702
335 Major Male Pelvic Procedure w/o CC	\$3,302	\$ 398	\$2,904
311 Transurethral Proc w/o CC	\$3,302	\$1,919	\$1,383

This data reveals that it is critically important to determine the MTF costs per DRG, vice using the same average amount for all DRGs.

PATIENT UTILIZATION

Patients Utilizing Inpatient Specialty Support Services						
Inpatient Service	Active Duty Pts	% of Svc Total	CHAMP Elig Pts	% of Svc Total	MEDI-CARE Elig	% of Svc Total
General Surgery	323	25%	749	59%	208	16%
Ophthalmology	32	15%	118	55%	64	30%
Oral Surgery	26	41%	34	54%	3	5%
ENT	218	38%	331	58%	18	3%
Urology	110	31%	190	54%	55	15%
Gynecology	75	15%	413	83%	7	1%
Obstetrics	149	21%	578	80%	0	0%
Orthopedics	360	57%	225	35%	50	8%
Mental Health	234	92%	19	8%	0	0%

RAPS ELIGIBLE POPULATION PROJECTIONS

Based on the RAPS Projection Model, the composition of the eligible population in the Charleston Catchment Area will experience the following changes by FY 1997.

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Active Duty	19,389	21.55%	7,566	12.22%
Dep Active Duty	35,176	39.10%	19,253	31.10%
Med Elig NG/Res	803	0.89%	714	1.15%
Dep of NG/Res	948	1.05%	837	1.35%
Retired	12,539	13.94%	12,483	20.17%
Dep Retired	18,218	20.25%	18,310	29.58%
Survivor	2,900	3.22%	2,734	4.42%
Totals	89,973	100%	61,897	100%

FUTURE COST AND SERVICE DELIVERY IMPACTS OF THE POPULATION TRENDS

As the younger Active Duty population leaves and the average patient age in the Catchment Area rises, the inpatient Specialty Support caseload will experience a similar shift. For example, the ENT surgeons may do fewer BMTTs and more septoplasties for their older population. Ophthalmology may see more cataract patients and fewer pediatric eye muscle surgery cases. General surgeons may do fewer pediatric hernias and more adult one as a result of age group shifts. Similar scenarios are likely for Oral Surgery, Gynecology, and Orthopedics.

CIVILIAN SECTOR, FEDERAL, TRI-SERVICE OR LEAD AGENT ISSUES

The civilian medical community in Charleston has an abundance of high quality, but under utilized, inpatient services with well established and well staffed medical delivery systems. The VA Medical Center in Charleston is currently offering to provide as many inpatient services as possible for military beneficiaries; however administrative hurdles (CHAMPUS billing) must be overcome before this will become a fully viable option for all MHSS eligible beneficiaries.

We have recently been informed that the Lead Agent Office is providing assistance & data to the Chief of Surgery at Eisenhower Army Medical Center in support of a Trauma Support Project, but are not yet aware of what part Naval Hospital Charleston may play in the project.

OUTPATIENT MARKET SHARE

This will be addressed in the Product Line Analysis for Outpatient Specialty Support Services.

INTERRELATIONSHIPS WITH GME OR OTHER CLINICAL SERVICES

The Family Practice Training Program ended in June 1994. At the time of this analysis the training activities in this facility are limited to training MUSC medical students, civilian surgical ENT & GYN training, and civilian nurse practitioner training. Discussions have begun for the establishment of another Family Practice Training Program at this facility in the future.

MISSION UNIQUE OR READINESS RELATED ISSUES

Maintaining a cadre of well trained surgical specialists who also have experience with operational/deployed platforms will improve readiness and mission capability (to the extent that the surgical skills are similar/comparable to the mission requirements). General surgeons, orthopedic surgeons, anesthesiologists, and similar specialists will

have future wartime roles which require some degree of specialized training which can be obtained from the MTF under certain circumstances. For example, training anesthesia providers with equipment they will be forced to use in the field -- equipment which is not authorized for use in any civilian hospital at this time.

RECOMMENDATIONS FOR FUTURE DELIVERY OF THIS PRODUCT LINE

Continue to provide all inpatient specialty support services that are currently provided in the MTF, and those that are being provided through External Partnerships and VA/DOD Resource Sharing Agreements.

Perform an in depth assessment of the Orthopedic services to determine the causes of the significant rise in cost between FY 93 and Fy 94. Efforts should then be made to improve those factors contributing to the high costs; and further evaluation performed to determine if it is cost beneficial to provide these services in the MTF.

**PRODUCT LINE ANALYSIS FOR
OUTPATIENT SPECIALTY SUPPORT SERVICES**

CLINICAL SERVICES

Service	MEPRS Codes
Dermatology	BAP
General Surgery	BBA
Ophthalmology	BBD
Otorhinolaryngology	BBF
Urology	BBI
Gynecology	BCB
Obstetrics	BCC
Orthopedics	BEA, BEB
Mental Health	BFA, BFB, BFF

COMPARISON OF COST DATA (FY 1994)

Service	MTF Expense	Estimated CHAMPUS Cost	Difference (MTF - CHAMPUS)
Dermatology	\$891,418	\$626,770	\$264,648
General Surgery	\$2,539,789	\$3,292,290	- (\$752,501)
Ophthalmology	\$727,309	\$813,761	(\$86,452)
Otorhinolaryngology	\$959,249	\$1,019,264	(\$60,015)
Urology	\$1,154,338	\$1,975,405	(\$821,067)
Gynecology	\$2,819,205	\$3,517,868	(\$698,663)
Obstetrics	0	0	0
Orthopedics	\$1,258,125	\$1,409,557	(\$151,432)
Mental Health	\$1,077,006	\$527,890	\$549,116
Totals	\$11,426,439	\$13,182,805	(\$1,756,366)

Outpatient Obstetric services are provided at Naval Hospital Charleston, but the workload and cost data is included in the Gynecology services.

The data displayed below shows the average cost per visit for each service, both in the MTF and through CHAMPUS.

Outpatient Service	MTF Avg Cost per Visit	CHAMPUS Avg Cost per Visit	Difference
Dermatology	121.63	85.24	36.39
General Surgery	173.70	225.16	(51.46)
Ophthalmology	116.09	129.89	(13.80)
Otorhinolaryngology	160.33	170.36	(10.03)
Urology	147.86	253.03	(105.17)
Gynecology	111.93	139.67	(27.74)
Obstetrics	111.93	153.54	(41.61)
Orthopedics	137.83	76.11	61.72
Mental Health	110.91	54.36	56.55

FACTORS AFFECTING MEPRS EXPENSES

During part of FY 94 the Mental Health Department included 2 Internal CHAMPUS Partnerships. One of these was terminated in December of 1993, and the other ended in the spring of 1994. The workload data for these CHAMPUS partners is included in the MTF MEPRS data.

Patients Utilizing Outpatient Specialty Support Services						
Outpatient Service	Active Duty Pts	% of Svc Total	CHAMP Elig Pts	% of Svc Total	MEDI-CARE Elig	% of Svc Total
Dermatology	2,060	28%	3,999	54%	1,294	18%
General Surg	2,265	15%	10,454	72%	1,903	13%
Ophthalmology	1,197	19%	3,086	49%	1,982	32%
ENT	1,970	33%	3,621	61%	392	6%
Urology	2,474	32%	3,806	49%	1,527	19%
OB/GYN	3,803	15%	21,032	84%	352	1%
Orthopedics	7,991	43%	9,294	50%	1,235	7%
Mental Health	5,689	59%	3,969	41%	53	0.5%

RAPS ELIGIBLE POPULATION PROJECTIONS

Based on the RAPS Projection Model, the composition of the eligible population in the Charleston Catchment Area will experience the following changes by FY 1997.

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Active Duty	19,389	21.55%	7,566	12.22%
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Dep Retired	18,218	20.25%	18,310	29.58%
Survivor	2,900	3.22%	2,734	4.42%
Totals	89,973	100%	61,897	100%

FUTURE COST AND SERVICE DELIVERY IMPACTS OF THE POPULATION TRENDS

Due to the closure of the Naval Shipyard & Naval Base, our total number of active duty sponsors and dependents will decrease significantly. On the other hand, the trend for our population of retirees and their dependents is to grow. These are the patients that increase the cost of care. Generally, they have more health problems of increasing complexity. Subsequently, the frequency of visits, time needed in each visit, and greater use of ancillary services (particularly pharmacy) result in increased costs.

CIVILIAN SECTOR, FEDERAL, TRI-SERVICE OR LEAD AGENT ISSUES

The beneficiary population that uses the MTF perceives that the quality of care is high. Most patients feel that private practices are more business/profit oriented and do not feel the warmth that they feel in the MTF. The majority express their desire to be cared for at the MTF. They view the quality of MTF medicine to be superior. For that reason, many patients will not see a CHAMPUS provider and instead avail themselves of every opportunity to get into the MTF (occasionally risking a medical condition).

OUTPATIENT MARKET SHARE

Outpatient Service	MTF Visits	% of Mkt Share	CHAMPUS Visits	% of Mkt Share
Dermatology	7,353	74%	2,620	26%
General Surgery	14,622	76%	4,652	24%
Ophthalmology	6,265	73%	2,281	27%
ENT	5,983	47%	6,695	53%
Urology	7,807	78%	2,198	22%
Gynecology	25,187	85%	4,333	15%
Obstetrics	Not Avail			
Orthopedics	18,520	56%	14,125	44%
Mental Health	9,711	25%	28,548	75%

INTERRELATIONSHIPS WITH GME OR OTHER CLINICAL SERVICES

The relationship with GME needs to be considered as residents from the civilian community participate in the specialty clinics. Productivity is not affected as much in the specialty product line and it is in the Primary Care Outpatient Product Line

because of the low numbers of residents in each clinic. Many of the residents have limited clinic hours, and therefore do not demand as much time from the Attending to proctor. Therefore the impact on cost is minimal.

MISSION UNIQUE OR READINESS RELATED ISSUES

Mission readiness and command training affects the product line as TADs, Training Standdowns, and deployments affect the number of appointment available in the course of a year. Long term deployments can reduce a small department's appointment availability by 33-50%.

RECOMMENDATIONS FOR FUTURE DELIVERY OF THIS PRODUCT LINE

Continue to deliver all of the services in this Product Line.

Perform another Product Line Analysis after the end of FY 95 to assess how significantly workload and costs have changed due to the termination of the Family Practice training program, and the formation of the military Group Practices (Primary Care Teams).

Perform more in-depth assessments of Orthopedics, Dermatology, and Mental Health to determine the causes of their average cost per visit exceeding the average cost per CHAMPUS visit. Efforts should then be made to improve those factors contributing to the high costs, and further evaluation performed to determine if it is cost beneficial to provide these services in the MTF.

Collect CPT Code data for all outpatient visits in the MTF that show what services were provided to the patient, as well as the CPT Codes for Evaluation & Management (99 series -- show if the patient is New or Established, and the length of the visit). Having this data available will allow for a comprehensive analysis to compare costs by CPT Code, and to determine the types of services actually provided to our beneficiary population.

PRODUCT LINE ANALYSIS FOR
ANCILLARY SUPPORT SERVICES

CLINICAL SERVICES

Service	MEPRS Codes
Nutrition	BAL
Social Work	BFE
Audiology	BHD
Occupational Health	BHG
Physical Therapy	BLA/DHD
Occupational Therapy	BLB/DHB
Preventive Medicine	FBB
Industrial Hygiene	FBC
Radiation Health	FBD
Immunizations	FBI

This product line also includes the Medical ICU, the Surgical ICU, Pharmacy, Pathology, Radiology, and Same Day Surgery. These services were not evaluated in this analysis as all of their costs have been allocated to the other inpatient and outpatient product lines. A complete rework of the entire year of MEPRS data was not feasible in the time allotted for this project.

COMPARISON OF COST DATA (FY 1994)

Service	MTF Expense	Estimated CHAMPUS Cost	Difference (MTF - CHAMPUS)
Nutrition	\$37,522	\$94,705	(\$57,183)
Social Work	\$626,502	\$63,859	\$562,643
Audiology	\$88,860	\$74,472	\$14,388
Occupational Health	\$1,468,716	Not Avail	
Physical Therapy	\$773,119	\$175,182	\$597,937
Occupational Therapy	\$141,000	Not Avail	
Preventive Medicine	\$361,385	Not Avail	
Industrial Hygiene	\$812,877	Not Avail	
Radiation Health	\$199,501	Not Avail	
Immunizations	\$125,948	Not Avail	

FACTORS AFFECTING MEPRS EXPENSES

Family Practice Resident Training is included in the FY 1994 workload and cost data, which may indicate higher acuity levels, longer lengths of stay, more frequent visits, and higher expenses than may be incurred in FY 1995 and beyond.

MEPRS workload data is not available for the Preventive Medicine, Industrial Hygiene, Radiation Health, and Immunization Clinics.

The Social Work Expense data includes \$94,903 for labor expended for the Family Advocacy Program.

PATIENT UTILIZATION

Patients Utilizing Ancillary Support Services						
Ancillary Service	Active Duty Pts	% of Svc Total	CHAMP Elig Pts	% of Svc Total	MEDI-CARE Elig	% of Svc Total
Nutrition	331	25%	649	49%	349	26%
Social Work	344	27%	703	54%	247	19%
Audiology	400	20%	1,496	73%	146	7%
Occup Health	2,326	11%	19,410	89%	2	
Physic Ther	13,691	79%	2,889	16%	851	5%
Occup Ther	1,953	67%	769	27%	184	6%

RAPS ELIGIBLE POPULATION PROJECTIONS

Based on the RAPS Projection Model, the composition of the eligible population in the Charleston Catchment Area will experience the following changes by FY 1997.

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Active Duty	19,389	21.55%	7,566	12.22%
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Survivor	2,900	3.22%	2,734	4.42%
Totals	89,973	100%	61,897	100%

FUTURE COST AND SERVICE DELIVERY IMPACTS OF THE POPULATION TRENDS

The current population being served and future trends indicate a decline in the pediatric age group and in the young adult group, corresponding to the downsizing of the Navy in Charleston. This will have a definite effect on several of the services in this product line. The most stable population group (retirees) will continue to benefit from clinical services such as Nutrition, Audiology, Physical and Occupational Therapy.

CIVILIAN SECTOR, FEDERAL, TRI-SERVICES OR LEAD AGENT ISSUES

The Lead Agent hospital for this area (Eisenhower Army Medical Center) is not proximate for the vast majority of beneficiaries served by Naval Hospital Charleston. The other federal institutions in the area (VA Medical Center & 437th Medical Group) do not provide the scope of ancillary services that is currently available at Naval Hospital Charleston (i.e., Preventive Medicine, Industrial Hygiene & Radiation Health).

OUTPATIENT MARKET SHARE

Sufficient MTF and CHAMPUS workload data is not available to perform a conclusive analysis of the market share.

INTERRELATIONSHIPS WITH GME OR OTHER CLINICAL SERVICES

The Family Practice Training Program ended in June 1994. At the time of this analysis the training activities in this facility are limited to training MUSC medical students, civilian surgical ENT & GYN training, and civilian nurse practitioner training. Discussions have begun for the establishment of another Family Practice Training Program at this facility in the future.

MISSION UNIQUE OR READINESS RELATED ISSUES

Mission readiness related issues are always a concern and have an implication for this product line. The practice of military medicine is a unique practice, and it appears clear from history that until we live in an ideal world, there will always be a need for the cost and expense of readiness, contingency planning, and deployment. These same concerns and costs are not shared in the same way in the civilian sector. Reducing or eliminating ancillary services which would weaken mission readiness could have grave implications for national defense.

RECOMMENDATIONS FOR FUTURE DELIVERY OF THIS PRODUCT LINE

Continue to provide all of the services in this Product Line.

Perform another Product Line Analysis after FY 95 closes, to determine the impact of the Naval Station and Naval Shipyard closures on these services -- especially Audiology, Preventive Medicine, Industrial Hygiene, and Radiation Health.

Develop a different set of methods to use in performing an analysis of Ancillary Support Services. Much of the needed cost and workload data is not available through the same sources as for inpatient and outpatient clinical services.

**TRICARE REGION III
CHARLESTON LOCAL AREA PLAN
FOR TRICARE IMPLEMENTATION**

ESSENTIAL ELEMENTS

MEDICAL READINESS AND CONTINGENCY SUPPORT: In the event of a mobilization, Naval Hospital Charleston will make every reasonable effort to retain the levels of service and care which were in place prior to the start of mobilization. Backfilling of any staff lost to mobilization will be done using available Reserve augmentation and any contract support personnel provided by the TRICARE Support contractor.

Approx. 87 military staff provider and support personnel at Naval Hospital Charleston would be lost if a full mobilization were to occur. However, the size of any contingency support is dependent upon BUMED manning requirements. In a contingency situation, the number of providers mobilized may range from zero, to all assigned to platforms, to all staff providers assigned to the command. Over the past three years, deployments have included Operations Desert Shield/Storm and a MMART tasking for a six month Med. float.

By FY 1996, it is expected that the mix and number of operational billets for the Naval Hospital will be significantly less, due to the closure of its Family Practice residency training program in June 1994. As a result, some of the billets for specialty providers who supported the residency program were removed from the hospital's billet structure. This, in turn, has reduced the number of providers assigned to operational billets.

RESOURCE MANAGEMENT: Potential Resource Sharing/Support opportunities within the Charleston service area will be used principally for covering demand for specialty care services not available within the MTFs. (Refer to section on NETWORK DEVELOPMENT). Some or all of the current partnership agreements (internal and external agreements) in and other agreements (e.g., CAMCHAS MTF) now in place may be likely candidates for conversion to Resource Sharing/Support agreements, or other contractual arrangements.

Primary care services will be delivered through the MTFs using a group/family practice model with Primary Care Managers (PCM) and empanelment. MTF Commanders, using DOD's TRICARE guidelines, will designate which beneficiaries categories are eligible, which categories are prioritized, reasonable commuting times and distances to assigned PCM locations, and determine the effective dates for enrollment periods for all TRICARE PRIME services and benefits. All active duty personnel will be automatically "enrolled". (technically, there is no TRICARE PRIME enrollment decision required of active duty personnel, however, they will be required to make an enrollment decision for and on behalf of their family members). MTF Commanders will identify to all enrollees those groups/teams or clinics which will offer PCM empanelment and how they will receive their primary health care.

Although primary care services are planned to be delivered through the MTF network, some limited primary care delivery capabilities may be also requested from the TRICARE Support Contractor if the MTF enrollment forecast is found to be off-target for Charleston and if primary care demand is not being met with existing MTF resources.

MTF Commanders will provide direction to the TRICARE Support Contractor regarding which specific specialty services will be referred to the MTF as an automatic first choice. Protocols and procedures for Nonavailability Statements (NAS) of MTF specialty services will be established prior to any referrals of TRICARE PRIME enrollees to TRICARE network providers and institutions. Non-enrollees will be encouraged to use MTF sources of specialty services as a first choice, if MTF space availability exists.

NETWORK DEVELOPMENT: The Charleston network plan for health care delivery under TRICARE will be based on a "Hub and Spokes" model which centralizes outpatient specialty and inpatient hospital care using Naval Hospital, Charleston as the "Hub" and always as a first choice when these services are available and can be provided internally. However, when services cannot be provided by the MTF, needed specialty and inpatient care will be supplemented by the TRICARE network resources locally and regionally, including the use of Specialized Treatment Facilities.

Beneficiaries who do not enroll in TRICARE PRIME and who do not take advantage of the cost savings afforded by TRICARE EXTRA, will be considered as TRICARE STANDARD users (CHAMPUS users) and will be seen in the MTF on a space available basis only. The TRICARE Support Contractor and its subcontracted Fiscal Intermediary will maintain total responsibility for CHAMPUS payments for these beneficiaries who remain TRICARE STANDARD users.

Navy facilities in Charleston which will offer primary care services (the Spokes) will be located at: Naval Hospital, Charleston and the MENRIV Branch Medical Clinic at Naval Weapons Station, Goose Creek. An additional spoke in the primary care model may include NAVCARE, however, this decision will require input from MTF Commanders and the TRICARE Support Contractor after contract award. When primary care services are limited due to MTF/clinic optimal capacity limits, MTF/clinic PCM locations will be supplemented by the TRICARE Support Contractor's civilian network of PCM locations in the Charleston area.

The TRICARE Support Contractor will "own" the TRICARE PRIME (HMO) and TRICARE EXTRA (PPO) civilian networks. Enrolled beneficiaries unable to be assigned to a MTF location will be assigned to a civilian network PCM by the MTF Commanders and the TRICARE Support Contractor using specific protocols.

When specialty care is not available within the MTF, specialty care will be provided by TRICARE network specialty providers. Resource Sharing/Resource Support agreements between MTF Commanders and the TRICARE Support Contractor for any needed specialty care services will be explored for future TRICARE PRIME beneficiary needs. These Resource Sharing/Support agreements, when exercised by MTF Commanders, will greatly help to: reduce any future uncertainties with military billeting requirements; reduce military billeting/specialty provider staffing levels; and decrease military direct care funding authorization levels for civilian contracts.

The Naval Hospital, Charleston's immediate future plan (by FY 1996) calls for specialty inpatient care to support a much smaller community based hospital with an inpatient service of between 40 and 65 beds. Inpatient admitting services will also offer a limited number of Operating Rooms, ICU (CCU) and PACU bed units. Future initiatives will look at various alternative programs for "Make (keep)/Buy (contract)" decisions for all inpatient specialty services currently offered.

ENROLLMENT/REGISTRATION: The first offering of enrollment to Charleston area eligible beneficiaries in TRICARE PRIME will be done according to protocols established by MTF Commanders. Enrollment will be based on a priority system using beneficiary categories in a phased approach as follows:

1. All Active Duty members
2. Families of active duty sponsors in pay grades E-4 and below
3. Families of active duty sponsors in pay grades E-5 and above
4. All remaining CHAMPUS eligible beneficiaries and their families

Although all active duty personnel will be automatically registered for enrollment in MTFs on an individual basis, strong emphasis will be placed on enrolling all active duty families together as intact family units.

All MTF enrollment activities conducted in the Charleston area will be coordinated by MTF Commanders using specific protocols. The initial enrollment offering will be considered an "open season" (continuous open enrollment period) until the MTFs reach their optimal PCM panel sizes and forecasted enrollment target levels by beneficiary category.

All enrollees will have the opportunity to disenroll at any time after 12 months of continuous enrollment, or sooner if they lose CHAMPUS eligibility or move out of the Charleston area. Disenrollment during the 12 month enrollment period for reasons other than for loss of eligibility or moving out of the area can only be authorized by MTF Commanders and will not normally be approved.

The Charleston enrollment forecast model will be based on using a MTF based approach initially with additional TRICARE Support Contractor involvement for the civilian network portion of TRICARE PRIME needed only if overall MTF enrollment demand exceeds forecast and MTF optimal capacity levels have been reached.

The enrollment forecast for Charleston is based on complete MTF control of initial enrollment activities. Because not all eligible beneficiaries will enroll in TRICARE

PRIME, the Charleston enrollment plan is conservatively forecast to obtain 100% of MTF optimal capacity within three years from start date of first enrollment period. The forecast for the first year of enrollment shows approximately 18,868 enrollees and grows to approximately 29,157 enrollees after three years. The enrollment forecast shown below uses methodologies obtained from enrollment forecasting experience from the HMOs, actual results of 1988-93 enrollment in CRI and other DOD sources:

TRICARE PRIME ENROLLMENT FORECAST

Enrollment Category	1	2	Year 3	4	5	Population by Category
Active Duty	100%	100%	100%	100%	100%	8,368
AD Families	20%	30%	40%	50%	50%	20,744
Retired	20%	30%	40%	50%	50%	12,458
Retired Families	20%	30%	40%	50%	50%	18,244
Over 65	5%	5%	5%	5%	5%	4,198
Total Beneficiaries						64,012
Total Enrollment	18,868	24,011	29,157	34,301	34,301	
PRIME Penetration	29%	38%	46%	54%	54%	

Notes: Eligible Beneficiary Population figures are from RAPS - Average population for FY 96 - this particular year's population figures have been straight-lined across all enrollment years as the representative total population for Fys 97-99.

SPECIALIZED TREATMENT SERVICE FACILITIES: Charleston area MTFs will utilize Eisenhower Army Medical Center at Fort Gordon, Augusta, Georgia as a Specialized Treatment Service facility (STS) to the fullest extent possible. Additional STSs may be utilized on a multi-regional and national level as needed and required. These STS facilities will be considered the preferred facilities for all eligible beneficiaries under TRICARE for the particular specialty service offered. In the event that mitigating circumstances prohibit patients from traveling to Eisenhower STS or to any other military or Federal STS for needed care, they may be referred to the Medical University of South Carolina (MUSC) for STS care as an alternate choice.

UTILIZATION MANAGEMENT/QUALITY MONITORING: The Charleston plan calls for all MTF based PCMs to be actively involved in UM/QM activities, ensuring both quality and appropriateness of all rendered medical care. MTF department heads and directors will be involved in reviewing practice, utilization, and referral patterns within their span of control. Specific functions of the MTF departments will include establishing a mechanism to monitor provider qualifications such as licensing, credentialing and any adverse actions. An on-going responsibility will be to analyze how MTF providers are performing relative to their TRICARE civilian network and non-network peers with regards to community standards for costs, utilization, and quality.

Accomplishing UM/QM in Charleston will require effective communication and interaction among the MTF staff; physician managers, nurses, ancillary and administrative staff all have important roles. A clear understanding of the UM/QM components and the philosophy of a managed health care system which TRICARE represents will allow the MTF Commanders, their "corporate UM/QM staff" and MTF designated UM/QM management to work within the departmental organization that best meets their needs.

Naval Hospital, Charleston's UM/QM department is headed by a Nurse Corps Officer and supported with other UM/QM support staff. Although Charleston's UM/QM plan is primarily MTF focused and controlled, Lead Agent and TRICARE Support Contractor involvement may be required to supplement existing UM/QM resources.

WELLNESS AND HEALTH PROMOTION: A key feature of the TRICARE PRIME plan is the enhanced benefits package offering wellness and health promotion services obtainable through MTF PCMs or directly through patient self-referral to programs available at MTFs. One of the best ways to manage health care costs is to provide ease of access to various programs which will help beneficiaries improve their health. Some examples of these programs to be offered and made available to enrollees in TRICARE PRIME and non-enrollees (on a space available basis) include:

- Nutritional planning and counseling
- Stress management
- Weight control
- Chemical dependency awareness
- Smoking cessation
- Hypertension management
- Diabetes management
- Pre-natal classes
- High risk pregnancy classes

Various Navy Occupational Health, Preventive Medicine, and Industrial Hygiene activities will be consolidated and moved into new spaces (due to closure of Branch Medical Clinics at Naval Shipyard and Naval Station) in remaining MTFs in Charleston in order to continue serving active duty personnel and beneficiaries.

TRICARE Support Contractor assistance may be required to supplement existing MTF activities in wellness and health promotion if remaining Charleston MTFs do not receive funding support and personnel resources to do the job.

GRADUATE MEDICAL EDUCATION: Naval Hospital, Charleston has served as the training site for a Family Practice residency program for many years. This training program was officially terminated at the close of the 1994 academic year (June 1994) and the last of the Navy residents left in December 1994. The termination of this program resulted in a loss of 34 billets; a significant portion of the primary care delivery and inpatient admitting staff at Naval Hospital, Charleston.

Naval Hospital Charleston is affiliated with several residency and clerkship programs with Medical University of South Carolina (MUSC), USUHS, and other civilian hospital based programs. General Surgery, ENT, Orthopedics, Ob/Gyn, and Oral Surgery

residents from MUSC do rotations at the Naval Hospital. Each of these specialties maintain a Memorandum of Understanding (MOU) with the respective department at MUSC which provides the framework for the affiliation.

These residents enhance the productivity and academic environment of the entire command by providing direct patient care under the supervision of Navy staff clinicians. Reciprocally, many of the hospital's staff have been given assistant academic appointments at MUSC. Additionally, Naval Hospital Charleston serves as a clerkship site for medical students from USUHS and civilian medical schools for their clinical rotations, especially during the summer months.

The Hospital also has a bimonthly Tumor Board conference where all new cancer patients are discussed in order to determine the best multi-modality management. These conferences are attended by representative clinical and other staff members as well as by representative staff members of MUSC and other hospitals and private medical groups from the Charleston area.

INFORMATION MANAGEMENT: Naval Hospital Charleston uses the Composite Health Care System (CHCS) as the primary information workhorse to collect, maintain, and retrieve data about the health service operations performed in the MTFs. This system has active modules that perform the following functions:

- Mailman - Electronic mail
- Patient Appointment and Scheduling (PAS) - patient appts/stats.
- Patient Administration (PAD) - patient registration/tracking, etc.
- Medical Services Accounting (MSA) - inpatient billing
- Pharmacy - order prescriptions
- Laboratory - order laboratory tests/procedures
- Radiology - order radiology tests/procedures
- Clinical Order Entry/Nursing - place ancillary orders

The most recent module activated is the CHCS-Managed Care Program (MCP) module. This module is critical to the successful operation of the future managed care activities in the Charleston service area.

The CHCS-MCP module provides automated capabilities to accomplish the following:

- Empanel to selected PCMs (MTF/provider specific)
- Establish a military and civilian health care network
- Appoint efficient booking to providers (MTF and civilian)
- Enroll beneficiaries in TRICARE PRIME
- Issue NAS authorization to seek non-network care

Care provided under the Supplemental Care, Purchased Health Care, and Cooperative Care Programs is monitored by using a local database program (Supplemental Medicine) that collects some of the following data elements: patient name and category; CPT code; rendering provider information; and accounting information to include actual cost.

Care provided by CHAMPUS authorized providers (network and non-network) is monitored by using the Managed Care Query Application (MCQA) software and the Catchment Area Management Information System (CAMIS). Updates to these systems are provided by the Office of CHAMPUS, via the Fiscal Intermediary, and contain detailed information about each CHAMPUS claim processed for care provided to beneficiaries in the Charleston catchment area.

TRICARE Support Contractor involvement in the area of information systems may be required depending upon local resources, management information system needs and regional Lead Agent requirements.

MARKETING AND EDUCATION: The Charleston Marketing and Education Plan will use a variety of marketing and education programs including various media strategies, TRICARE videos, telemarketing functions through Health Care Finders, direct mail efforts, including fliers and newsletters, command and community briefings, wellness and health fairs, and other personal contact methods to introduce beneficiaries, providers and support staff to the features and enrollment procedures of TRICARE PRIME. The Plan will also help ease the transition to new product name awareness for the three tiered options to be made available under TRICARE.

The Plan's principal thrust will be through the following activities: implementing communication strategies required to inform users, providers, and staff of new, cost-effective, and quality healthcare products available in the TRICARE Program; understanding healthcare needs and unique area demographics; identifying and target marketing to the potential enrollment population in TRICARE PRIME.

The Charleston Marketing and Education Plan effort is based on MTFs receiving funding and personnel resources to do appropriate MTF based marketing and related communications. If resources and funding are not available within the MTF, these marketing activities will be assumed by the TRICARE Support Contractor.

ACCOUNTABILITY AND EVALUATION: The MTF Commanders will establish management support services that support the achievement and maintenance of the quantitative and qualitative standards for program integrity, correspondence control, payment record submissions, fiscal controls, and the handling and completion of appeals. This area will be a major part of the Utilization Management function overall for ensuring that appropriate outcomes strategies and performance measures are used and evaluated for improvement.

Charleston's accountability and evaluation activities will be primarily MTF driven and controlled functions, however, some Lead Agent input and TRICARE Support Contractor involvement may be necessary.

MARKETING AND EDUCATION PLAN

Objective:

The Marketing and Education Plan (The Plan) for the Charleston Catchment Area will focus on encouraging beneficiary enrollment in TRICARE PRIME or participation of beneficiaries and providers in TRICARE EXTRA and educating all beneficiaries, participating providers and MTF support staff on the characteristics and use of TRICARE's triple option benefit plan. Additionally, The Plan will educate MTF's and network providers on TRICARE PRIME managed care principles, utilization management strategies, proper referral policies and optimal use of resources both within and outside the catchment area.

The Plan will use a variety of marketing programs including various media strategies, TRICARE videos, telemarketing efforts using Health Care Finders, direct mail efforts, and command and community area briefings and personal contact methods to introduce beneficiaries, providers and support staff to the features and enrollment procedures of TRICARE PRIME. The Plan will also ease the transition from existing Charleston managed care products (e.g, CAMCHAS preferred provider network and Health Care Finders function) with the new benefit plan features and new product name of TRICARE EXTRA and TRICARE Service Center in order to achieve product awareness and better understanding.

The Plan's principal thrust will be through the following activities: implementing communication strategies required to inform users and providers of new, cost effective, and quality healthcare products; understanding healthcare needs and unique area demographics; and identifying the potential enrollment population in TRICARE PRIME for initial and on-going concentrated target marketing efforts. Additionally, The Plan will help improve access to healthcare by understanding existing and future provider needs, identifying their geographic and demographic distribution for MTF, network and non-network providers.

On a continuing basis, The Plan will be reviewed and expanded as necessary to include seminars, presentations, etc., linked with other MTF Wellness and Health Promotion activities to inform beneficiaries about beneficial health practices and services available to them with the TRICARE benefits package available in the

enrollment option, PRIME.

The Plan will ensure that all marketing materials developed are consistent and accurate, are coordinated with both Lead Agent and TRICARE Support Contractor marketing efforts, offer marketing direction and practices that are cost effective, and ensure that overall enrollment and other target marketing goals are being met.

Level of involvement with TRICARE Support Contractor

The Plan's development and administration can be provided by existing MTF marketing activities and military managed care resources in Charleston. Minimal contractor assistance is contemplated at this time.

The Plan will include the following key features:

- * Marketing literature and enrollment materials which will feature complete and accurate information about TRICARE PRIME, EXTRA and STANDARD benefits programs highlighted by informative spreadsheet comparisons of benefits, features, restrictions.
- * Information presentations, to be given to targeted groups at various MTF's, military commands, and other Charleston area locations, featuring the new benefits programs with audio-visual presentations using slides, video, as well as selected speakers/presenters from managed care offices, MTF's, command representation, and others.
- * Notification to beneficiaries which will feature early notification to all CHAMPUS beneficiaries who are targeted for enrollment in PRIME, and to all other beneficiaries with feedback and response through a local telephone number direct to the Charleston TRICARE Service Center (Health Care Finders) and a toll-free telephone number to call for more information about the various TRICARE benefits programs.
- * Advertising/Promotion of TRICARE product lines which identifies the full complement of media advertisement resources available and discusses the criteria by which the different media will be evaluated to best meet the

needs of the beneficiary population within the Charleston Catchment Area.

- * Wellness and Health Promotion presentations which provide beneficiaries with a cost-effective and convenient means to learn about important health issues.
- * Health Fairs which provide different age group categories of eligible beneficiaries with an excellent means to learn about relevant health topics and receive basic healthcare treatment at participating screening clinics.
- * The Implementation Plan which discusses how The Plan identifies proposed time frames for early notification, overall program initiation, functional responsibilities, and delineation of responsibilities between MTF's, their managed care departments and the MTF Public Affairs Offices.

Marketing Literature And Enrollment Materials

The MTF Marketing Department will develop marketing information materials that clearly define the managed care product offerings of both TRICARE PRIME and EXTRA. These materials will include:

For TRICARE PRIME:

- 1) A plan benefits description and coverage brochure listing benefits, limitations, restrictions, exclusions, eligibility, enrollment rules, and any user fees, and copayment obligations, as applicable.
- 2) A "How to use" brochure describing the available health care resources (MTF/network/Other), how to select a primary care manager (PCM), how to access the health care system using the TRICARE Service Center (Health Care Finders), claims appeal and arbitration process, and the most commonly asked questions and responses to those questions concerning the new TRICARE programs.
- 3) A map of TRICARE PRIME PCM providers at MTF's or other civilian provider locations, if appropriate.

4) An enrollment form which states the nature of the enrollment, length of enrollment lock-in, and the general restrictions applicable to the PRIME benefits plan. The enrollment form requires the signature of sponsor or adult Head of Household.

5) A comparison of benefits spreadsheet which compares TRICARE's PRIME, EXTRA, and STANDARD benefits, user fees, copayments, and deductibles.

6) A TRICARE PRIME membership card which will show effective dates, primary care manager (PCM)/and PCM site selected, copayments, and regular/after-hours emergency telephone numbers.

7) Periodic surveys which ask for enrollee preferences on Wellness program activities, overall satisfaction with access to care, quality of care, and other plan demographics.

For TRICARE EXTRA:

1) A benefits description brochure listing benefits, limitations, restrictions, exclusions, copayments, deductibles, co-insurance responsibilities, and a brief narrative describing access to a TRICARE EXTRA provider.

2) A listing and map of EXTRA provider locations.

3) A "How to use" brochure or info. sheet describing how to access the EXTRA network using Health Care Finders, commonly asked questions of EXTRA and responses to those questions, and grievance and arbitration process.

4) A comparison of benefits spreadsheet comparing the various TRICARE benefits plans to EXTRA.

5) Surveys to measure overall beneficiary satisfaction, access to care, quality of care, and other plan demographics.

Information Briefings And Presentations

Information presentations are critical to the initial and continuing education of beneficiaries, target groups, CHAMPUS Health Benefits Advisors, military personnel, and providers. The MTF Marketing Department will coordinate all such proposed informational activities and offer them at MTF's, military commands, and other Charleston area locations, including presentations to selected hospitals and providers within the EXTRA network.

The Marketing Department's representatives, others within the TRICARE Liaison Office and others (e.g., Public Affairs Office) will be designated as Information Facilitators in support of marketing efforts. These individuals will be available for group presentations, as well as one-on-one question and answer sessions. Information Facilitators will be able to provide enough information to beneficiaries about the enrollment process but will not be responsible for enrolling beneficiaries into PRIME; TRICARE Service Center marketing representatives and Health Care Finders will be responsible for the enrollment function.

A typical listing of locations at which marketing/information presentations will be given include:

- * At the TRICARE Liaison Office.
- * MTF's, local and regional military commands, Community Affairs/Services Offices, CHAMPUS Office (HBAs) TRICARE Service Center(s), and other military support offices deemed appropriate.
- * Military installation service support/women's clubs and their related service and community activity functions.
- * Retiree association groups (e.g., Charleston Office of The Retired Officers' Association-TROA) and their sponsored activities.
- * Selected Hospitals and provider locations in the Charleston community.
- * Health Care Consumer Council Meetings

Direct Mail Notification To Beneficiaries

The notification to Active Duty members and their families, other MTF users, and all CHAMPUS beneficiaries will consist of a direct mail campaign involving mailings to the sponsor or adult head of household. The initial mailing will be sent to specific groups that have been identified as potential enrollees in PRIME and will consist of an introductory letter, signed by the Commanding Officer of Naval Hospital, Charleston announcing the new TRICARE benefits programs to beneficiaries in the Charleston service area. The initial mailing will include a benefits/cost comparison of the various benefit plan options available and a listing/map of participating MTF's and network providers. A mail-in response/tear-off and return post card will also be included to help measure return rate and beneficiary interest in the new programs.

TRICARE Advertising And Program Promotion

Various advertising and promotion programs will occur continuously during the initial open enrollment period and as a part of selected open enrollment periods thereafter (if required). Specific activities not associated with enrollment will also be tied to special marketing campaigns associated with health promotion, non-network CHAMPUS users, optimal use of benefits, TRICARE Service Center and Health Care Finders, and other MTF marketing related issues. Media selection will be based on standard advertising criteria:

- * Demographics/characteristics of targeted markets
- * Communication needs
- * Product awareness needs
- * Cost effectiveness of The Plan
- * Reach vs. Frequency studies

Using these criteria, the MTF Marketing Department will select advertising media which will best meet the needs of the TRICARE beneficiaries. The MTF Marketing Department will always seek approval from the Public Affairs Officer and Commanding Officer of Naval Hospital, Charleston prior to final decision of advertising media selected.

Advertising media which may be used includes:

- * Spot Television (military cable T.V./community bulletin board)
- * Spot Radio
- * Outdoor Media, including
 - billboards
 - bus shelters/benches
 - Bus transit signs
- * Direct Mail
- * Newspapers, selected journals
- * Military Association Newsletters and Publications
- * Military Base and Armed Services Publications

Wellness And Health Promotion Presentations

A key feature of The Plan is the emphasis placed on Wellness and Health Promotion. The TRICARE PRIME benefits program will offer previously unavailable preventive medicine and health education benefits/services as a part of the enrollment benefits package. A major marketing effort will be aimed at achieving optimal health maintenance through use of MTF health education programs and Wellness/Health Promotion Center together with a MTF coordinated community health education program with published calendar of activities using both MTF and outside resources.

Seminars and classes will be coordinated through the Health Education department/Wellness Center. These seminars and classes may be conducted at other MTF's. Non-MTF locations may also be used depending upon the degree of involvement, frequency offered, and competition with community based health education/Wellness resources.

Some examples of these types of wellness activities available include:

- * Nutritional planning and counseling
- * Weight control
- * Smoking cessation
- * Chemical dependency awareness
- * Stress Management/awareness
- * Hypertension management
- * Diabetes management
- * Pre-Natal classes
- * High-risk pregnancy classes

Health Fairs

Health Fairs offer an interesting and accessible way for beneficiaries to become better educated and actually tested or screened for certain health problems. Health Fairs, both promotional and health oriented, are an integral component of The Plan's marketing strategy.

Health Fairs include booths featuring demonstrations, brochures, self-help guides, and other related information. The focus of the Health Fair may include the following:

- * Pediatric Health Fairs, which can include well baby/child care information and demonstrations, health screening, and immunization schedule information.
- * Adolescent Health Fairs, which can include health screening and selected

informational seminars directed at adolescent concerns such as weight control, nutrition, acne care, eating disorders, stress management, substance abuse, weight control, and exercise.

- * Well Women Health Fairs, which include information on breast exams, pelvic screening, and other selected seminars directed toward the health and lifestyle planning for the adult female.

- * Retiree Health Fairs, which include seminars and classes geared toward the special needs of this military retiree population. Screenings for disease and other health information on nutrition, exercise, and older lifestyle needs are important.

Implementation of the Marketing Plan

All marketing materials will be submitted in draft format and reviewed by the Public Affairs Officer and the Commanding Officer at least 90 days prior to the implementation start date of the TRICARE Managed Care Program in Charleston. The media campaign strategy proposed will be submitted for approval with implementation to begin no later than 120 days prior to the start of TRICARE.

IX. STRATEGIC ACTION PLAN - OPERATIONAL ISSUES

Naval Hospital Charleston is currently exploring new and better ways of "doing business" through use of implementation strategies based on information contained in this Business Plan, survey results from both staff and health care consumers, internal source input from Directors and other key staff personnel, and external source direction from BUMED. An off-site planning session will be held on 26 May to produce recommended action steps and development strategies for business improvement. The results of this strategic planning meeting will be incorporated in this section of the Business Plan when finalized.

Several business improvement proposals are now (May-June 1995 time frame) being studied for immediate action and implementation:

- * Re-engineering and re-alignment of existing Primary Care Group Teams
- * Improved integration and seamless appointment functions with NAVCARE
- * Relocation to new areas within the hospital of certain outpatient and inpatient services
- * Further development and expansion of existing DOD/VA Resource Sharing Agreement (Refer to explanatory note below)
- * Enhancements to provider and support staff requirements using innovative interservice agreements to obtain Air Force personnel

Note on DOD/VA Strategy: By moving existing PCC (Green Team) from present location to a new one within the hospital, the VA could set-up a satellite clinic in this space. In exchange, the Naval Hospital would gain the services of a dedicated Medical/Surgical ward at the downtown Charleston VA Medical Center. The umbrella agreement would allow for purchase of pharmaceutical drugs via VA economy of scale buying power and their lower costs per unit purchased. Consult overload services for all specialty services would be enhanced. Existing MOUs (e.g., Mental Health and Cardiology) would be expanded.

NAVAL HOSPITAL CHARLESTON

EXPIRED EXTERNAL PARTNERSHIPS

TAB O

Service	Provider	Start	End	Reimbursement	Est. Workload
Urological Lithotripsy	Roper Hospital	Aug 92	Oct 94	\$2700/Case	20 Cases per year (1)
Cardiac Catheterization	Roper Hospital	Aug 92	Jun 94	See Below (2)	24 Cases per year (1)
Notes:	(1) Circumstances resulting in an admission revert to DRG payment, less the CAMCHAS percentage discount.				
<div>(2) Left Heart and Coronaries600</div> <div>Right & Left with Coronaries600</div> <div>Percutaneous Transluminal</div> <div>Coronary Angioplasty2000</div> <div>Telemetry Beds500</div> <div>Non Telemetry Beds400</div> <div>Coronary Care Unit Beds750</div>					

NAVAL HOSPITAL CHARLESTON

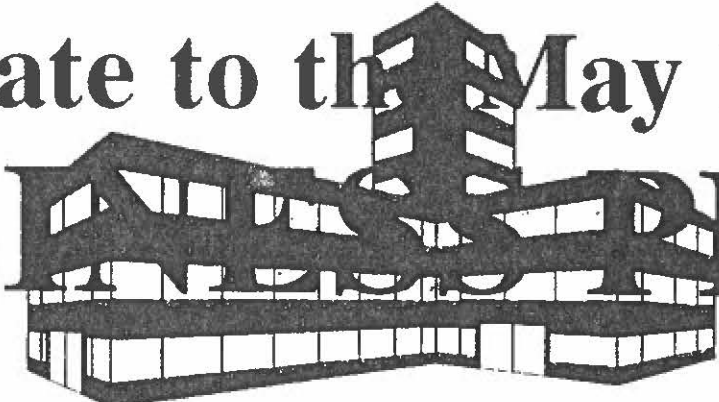
TERMINATED/EXPIRED INTERNAL PARTNERSHIPS

TAB O

Service	Provider	Start	End	Percent CMAC	Actual FTEs
Psychology	J. A. Basile, Ph.D.	Sep 91	Jun 94	50%	1.0 Psychologist
Psychology	Southeastern Psychological Services	Aug 90	Jan 94	58%	2.8 Psychologist
Psychiatry	Southeastern Psychological Services	Nov 91	Jan 94	80%	1.2 Psychiatrist
Pediatrics	Medical University of South Carolina	Apr 90	Sep 92	65%	1.0 Pediatrician
Internal Medicine	Spectrum Partnership Services	Nov 90	Aug 94	80%	1.0 Internist
Gastroenterology	Lowcountry Gastroenterology Associates, P.A.	Nov 90	Dec 91	100%	1.0 Gastroenterologist
Family Practice	Medical University of South Carolina	Oct 91	Jan 94	65%	4.0 Providers 3.0 Support
Family Practice	Baker Hospital	Oct 89	Oct 93	65%	4.0 Providers 3.0 Support
Anesthesiology	K. I. Schlesinger, M.D.	Jan 90	Jul 93	80%	0.2 Anesthesiologist
Radiology	Spectrum Partnership Services Resources	May 90	Apr 95	65%	1.0 Radiologist

Naval Hospital Charleston, SC

Update to the May 1995 **BUSINESS PLAN**



Oct 1995

The objective of this update is to provide current information surrounding the operating environment of Naval Hospital Charleston. The vast majority of the information contained in the May 1995 Business Plan is accurate and remains current. This update will include information from the original plan and highlight specific changes that should be considered in the decision making process of future endeavors. We have chosen to briefly touch on each section of the original plan and focus on updating the Product Line Analysis (PLA) as the PLA is normally relied upon for healthcare delivery decisions and contains some of the most volatile information.

I. INTRODUCTION - The history, location, mission, vision and, guiding principles of Naval Hospital Charleston (NHC) remain relatively unchanged. However, the mission statement, vision, and guiding principles have been included in this update as a courtesy to readers. There has been significant turnover in key staff members providing new leadership for the command. An updated key staff member listing has been included in this update.

History	NC
Hospital Location	NC
Mission	1
Vision	1
Guiding Principles	1
Key Staff	2

II. EXTERNAL ENVIRONMENTAL FACTORS - The geographic, economic, and transportation information contained in the original plan remain current. Although there has been little change in the demographics of the metropolitan population, an update on the demographics of our beneficiaries has been obtained and provided in Section IV.

Geography	NC
Economic/Political	NC
Demographics	NC
Transportation	NC

III. COMPETITOR ANALYSIS - The competitor analysis contained in the original plan remains current. Although there have been some new relationships established in the local community (i.e. MUSC/HCA), the capabilities of local providers of care remain relatively unchanged.

Hospitals:	NC
Background and Philosophy	NC
- Bed Type	
- Physician Numbers	
- Services Offered	
- General Information	
- CAMCHAS Relationship	
PPOs	NC
HMOs	NC

NC = No change, or not included in this update

IV. MTF INTERNAL ENVIRONMENT - In only a few short months the internal environment has changed dramatically. The impact of Base Realignment and Closure (BRAC) and the demographic shift of our beneficiary population are well underway. Although many of the internal environment areas have changed, we have chosen to update only those areas we felt had significant changes, or contained information imperative to future decision making capabilities.

Demographics	3
Effects of BRAC	6
Empanelment of Beneficiaries	7
Staffing	8
Hospital/Clinical Capabilities	NC
Facility MILCON Projects	NC
Referral Patterns	NC
Supplemental Care Expenditures	9
Partnerships/MOUs/Contracts	10
Readiness/Contingency	NC

V. STRATEGIC GOALS/PERFORMANCE MEASURES - The Strategic Goals/Performance Measure have not changed and are included in this update as a courtesy to readers.

Strategic Goals/Performance Measures	12
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VI. PRODUCT LINE ANALYSIS - As mentioned in the introduction, the PLA contains some of the most informative and volatile information in the Business Plan. The analysis relies upon MEPRS data for the first 10 months of FY95 and CHAMPUS data for FY94.

Inpatient Primary Care	15
Outpatient Primary Care	19
Inpatient Specialty Support	24
Outpatient Specialty Support	28
Ancillary Support	33
Recommendations	35

VII. TRICARE ESSENTIAL ELEMENTS PLAN NC

VIII. MARKETING AND EDUCATION PLAN NC

IX. STRATEGIC ACTION PLAN NC

NC = No change, or not included in this update

MISSION

Our mission is to keep the active duty members of all Armed Services healthy, and to provide health care to their families and other beneficiaries entrusted to our care.

VISION

Our vision is to be the model primary care community hospital in an integrated Department of Defense managed healthcare delivery system.

GUIDING PRINCIPLES

- * Customer service will be our primary focus in all decision making.
- * Recognize that our primary mission is to support combat readiness.
- * Manage the delivery of health care services, balancing access, quality, and cost containment.
- * Care for all persons as unique human beings worthy of our best professional efforts applied with courtesy, compassion, and respect.
- * Guard against inflexibility which interferes with meeting the needs of our customers.

**NAVAL HOSPITAL CHARLESTON
KEY STAFF MEMBERS**

COMMANDING OFFICER	CAPT K.L. Martin, NC, USN
EXECUTIVE OFFICER	Col J.A. Lee, USAF, MSC
DIRECTOR FOR ADMINISTRATION	CDR P.W. Lund, MSC, USN
DIRECTOR FOR PATIENT SERVICES	CAPT M.A. Southerland, NC, USN
DIRECTOR FOR CLINICAL SERVICES	CAPT J. J. Vicens, MC, USN
DIRECTOR FOR MANAGED CARE	CDR M. M. Allard, NC, USN
COMPTROLLER	LT G. L. Creech, MSC, USN

MTF INTERNAL ENVIRONMENT

DEMOGRAPHICS

By analyzing current and projected population figures, according to age and gender, it is easy to detect various beneficiary/user trends. As a result of Base Realignment and Closure (BRAC) 93 decisions and the expectations that families of those military personnel transferred elsewhere will also move out of the Charleston area, the figures for all projections through FY 1999 indicate that this population's age/gender groupings of mostly younger active duty members and their families are expected to decrease steadily over the same time periods. However, as this younger population leaves the Charleston Catchment Area, the population of males and females over the age of 65 is expected to steadily increase.

While not surprising anyone, according to the Navy afloat component of active duty and their families, the entire population making up this category is going to show the greatest losses over the next few years. Dramatic decreases in the number of active duty afloat and families will occur by the end of FY 1996.

According to reports on utilization of primary care services, there are certain age groups that utilize these services more frequently than other age groups. For example, The retired population and their families utilize internal medicine more than any other subset of the total beneficiary population. The greatest overall utilization trends are seen in the male retired population ages 45 to 64. This group's use of internal medicine services is about twice that of any other category. The same population also utilizes general surgery services more than any other subset of the total beneficiary population.

RAPS ELIGIBLE POPULATION PROJECTIONS

Based on the RAPS Projection Model, the composition of the eligible population in the Charleston Catchment Area will experience the following changes by FY 1997.

Beneficiary Category	FY 1994 People	FY 1994 Percent	FY 1997 People	FY 1997 Percent
Active Duty	19,389	21.55%	7,566	12.22%
Dep Active Duty	35,176	39.10%	19,253	31.10%
Med Elig NG/Res	803	0.89%	714	1.15%
Dep of NG/Res	948	1.05%	837	1.35%
Retired	12,539	13.94%	12,483	20.17%
Dep Retired	18,218	20.25%	18,310	29.58%
Survivor	2,900	3.22%	2,734	4.42%
Totals	89,973	100%	61,897	100%

Source: Resource and Analysis and Planning System (RAPS), April 1995

DEFENSE MANPOWER DATA CENTER

Current DEERS demographic data indicates that our beneficiary population decrease/shift is well underway. Although the data source (DEERS) is not always the most reliable, the below listed table does show suspected trends taking place. Last year active duty members and their dependents accounted for 60% of the total beneficiary population. Today, they account for only 50% of our catchment area with further shifts anticipated. As of 1 October 1995, the complete demographic make-up of the catchment area is as follows:

Beneficiary Category	October 1995 People	October 1995 Percent	Cumulative Percentage
Active Duty	10,292	14.1%	14.1%
Dep Active Duty	26,734	36.6%	50.7%
Retired	9,987	13.7%	64.4%
Dep Retired	18,496	25.4%	89.8%
Medicare Eligible	7,420	10.2%	100%
Totals	72,292	100%	100%

Source: Defense Manpower Data Center, October 1995

EFFECTS OF BRAC 93 & 95

Still Open for Business!

The Naval Hospital Charleston was not placed under consideration for closure or realignment by BRAC 95. This decision means that Naval Hospital Charleston will remain open to provide medical care to its eligible beneficiary population.

New Naval Installations?

BRAC 95 directed movement of the Navy Nuclear Power Propulsion Training Center from Orlando, Florida. As of Oct 1995, Charleston Naval Weapons Station has been selected as the site for the training center. This move would bring an estimated additional 500 staff instructors and approximately 2,500 active duty students to the area. The impact on increased demand utilization of services at Navy MTFs in Charleston is unknown at this time.

Naval Station Branch Medical Clinic

As a result of BRAC 93, the Naval Station Branch Medical Clinic closed in August 1995.

Charleston Naval Shipyard Branch Medical Clinic

Due to BRAC 93, the Charleston Naval Shipyard Branch Medical Clinic is scheduled to close in November 1995. The clinic primarily serves as an occupational health and industrial hygiene site for civilian employees of the Shipyard and Naval Station.

Naval Hospital Charleston

BRAC 93 adjusted population figures indicate that the number of active duty personnel within the Charleston Catchment Area will be reduced to approximately 12,765 members (average for year) by September 1995. It is estimated there will be an additional 61,652 (average for year) family members and retirees remaining in the Charleston Catchment Area. By the end of FY 97, the total number of beneficiaries, including active duty personnel, is projected to drop to 61,897.

As a result of the reduction in the active duty population, the Naval Hospital Charleston has been reduced from its 90 bed status to a facility of 40 beds. Each clinical service currently offered will be evaluated for continuation, based upon several factors which include: economic viability, efficiency, necessity to support the primary mission (operational readiness), availability of services within the community. Due to limitations on the number and requirements for specialty providers, some clinics may be/have been consolidated and/or restructured to achieve maximum efficiency.

Inpatient OB and Newborn Nursery

Naval Hospital Charleston stopped providing in house Obstetrical care and Newborn Nursery care on 01 October 1994. The hospital replaced its inhouse services with a more cost effective External Partnership agreement with Trident Regional Medical Center for these services. Under this partnership agreement military providers continue to provide the professional services, and the civilian partner will provide the facility and ancillary services. Currently, research and statistical analyses are underway to determine the true cost savings of this effort and to make recommendations regarding continuation of the external partnership.

Empanelment of beneficiaries

To assist patients in obtaining easier access to primary medical care services, the Naval Hospital is offering an opportunity for beneficiaries to become assigned to a primary care manager (PCM). The PCM will act as a gatekeeper to provide the primary and specialty medical care needs of the patient. Once the patient has been assigned to a PCM, they will be required to contact their PCM prior to receiving any primary or specialty medical care. The PCM will provide assistance to the patients in obtaining the appropriate level of care.

Navy MTF empanelment is currently offered on Teams Gold, Red, and Green (PCC) at Naval Hospital, and to the MENRIV Branch Medical Clinic, Naval Weapons Station. The 437th Medical Group, Charleston Air Force Base began its empanelment process in mid-1995. The empanelment process is designed to give beneficiaries consistency in obtaining medical care and easier access to medical care. Beneficiaries will still be able to use the Naval Hospital Emergency Room, NAVCARE, and the CAMCHAS preferred provider network regardless of their empanelment site.

Reduction of Hospital Staff

The Naval Hospital Charleston currently has 160 officers, 460 enlisted and 384 civilian employees onboard as of 16 Oct 1995. Due to the reduction of the hospital operating budget, the Naval Hospital has developed a plan to further reduce staffing to 136 officers, 244 enlisted and 374 civilians. Current staffing is comprised as follows:

NAVAL HOSPITAL MILITARY STAFF

	MC	DC	NC	MSC	ENL
BILLETS	76	2	110	42	466
ONBOARD	47	2	84	27	460
INPATIENT CARE			53		62
AMBULATORY CARE	40	2	24	7	154
ANCILLARY(SUPPORT)	6			6	92
OTHER ROLE	1		7	14	152

NAVAL HOSPITAL CIVIL SERVICE STAFF

	Drs	RNs	LPNs	PAs	OTHs
BILLETS	2	17	40		337
ONBOARD	2	11	29		342
INPATIENT CARE		5	14		3
AMBULATORY CARE	1	3	13		43
ANCILLARY (SUPPORT)					39
OTHER ROLE	1	3			256

Source: NHC Manpower Office, October 1995

SUPPLEMENTAL CARE EXPENDITURES

	FY 93	FY 94	FY95
SUPP HLTH	\$1,437,116	\$1,141,764	\$480,715
PURCH HLTH	\$226,184	\$42,720	\$769,169
TOTALS	\$1,663,300	\$1,184,484	\$1,249,884

(Source: NC 2171 for FYs 93,94, and 95)

PARTNERSHIPS/MOUs/CONTRACTS

PARTNERSHIPS AND TRICARE

Existing Partnership Agreements will cease to exist in an MTF's catchment area upon implementation of that region's TRICARE contract. Projected implementation date for Region Three is 01 June 1996. To obtain those same healthcare services after TRICARE is in place, an MTF may elect to:

- (a) convert to a health services contract;
- (b) convert to military and civil service personnel;
- (c) convert to a Resource Sharing Agreement with the TRICARE Contractor;
- (d) use the TRICARE Contractor's civilian network providers.

Conversions to a contract or military/civil service personnel will require approval and funding from BUMED. Conversion to a Resource Sharing Agreement can be declined by the TRICARE Contractor. Resource Sharing Agreements must be approved by the Lead Agent and the OCHAMPUS Contracting Officer, contingent upon any adverse financial effects on bid price adjustment to the TRICARE contract.

ACTIVE EXTERNAL PARTNERSHIPS

Service	Provider	Start	End	Percent CMAC/DRG	Est. Workload
Urological Lithotripsy	Trident Regional Medical Center	Oct 94	Oct 96	\$2800	70 Cases per year (1)
OB/GYN/Newborn Nursery/Peds	Trident Regional Medical Center	Sep 94	Oct 96	85%	480 Deliveries/year (2)
Notes: (1) Circumstances resulting in an admission revert to DRG payment, less the CAMCHAS percentage discount. (2) Obstetrical patients receive prenatal care at MTF. Delivery and newborn care at partnership facility by MTF physicians.					

Source: Market Analysis, October 1995

ACTIVE INTERNAL PARTNERSHIPS

Service	Provider	Start	End	% CMAC	Actual FTEs
Radiology	Spectrum Healthcare Resources	Apr 95	Apr 97 (1)	66%	1.0 Radiologist
Gynecology	Spectrum Healthcare Resources	Apr 92	Jun 96 (2)	65%	1.0 Nurse Practitioner
Obstetrics	Pinnacle Health Care	Apr 92	Jun 96 (2)	65%	1.0 Nurse Midwife
Cardiology	Coastal Cardiology	Aug 94	Aug 96 (1) (3)	90%	1.0 Cardiologist (current use: 0.2)
Pediatric Ophthalmology	M. E. Wilson, M.D.	Jul 92	Jul 96 (2) (3)	88%	0.1 Pediatric Ophthalmologist
Primary Care Clinic	Spectrum Healthcare Resources	May 94	May 96 (1)	65%	3.0 Family/General Practice 1.0 Nurse Practitioner/ Physician's Assistant
<p>Notes: (1) Agreement has two year renewal option available.</p> <p>(2) Agreement is in option period, not renewable.</p> <p>(3) CAMCHAS MTF Provider Agreement under CAMS demonstration authority.</p>					

Source: Market Analysis, October 1995

STRATEGIC GOALS, OBJECTIVES, AND MEASUREMENTS

Strategic Goals, Objectives, and Measurements for Naval Hospital, Charleston have been reviewed, examined and further realigned by the Executive Support System (ESS) working group. The ESS working group's January 1995 progress report and update to the Executive Steering Committee (ESC) listing the changes recommended and performance measurements required follows:

GOAL 1:"WE WILL MAINTAIN OPERATIONAL READINESS"

- * Maintain 80% C-1/C-2 Status
- * Maintain 100% of Staff Medical and Dental Records in the MTF System with annual verification
- * 100% annual PRT pass rate for individuals meeting instructional requirements for participation

Initiatives: Implement policy for enhanced medical accessibility/availability for deployment imminent platforms, internal and external to the command.

GOAL 2:"WE WILL MAXIMIZE THE COORDINATION AND UTILIZATION OF RESOURCES"

- * Designated Billets filled by qualified/trained individuals
- * Full identification of Third Party Payors with a 80% collection rate
- * Annual reduction of hospital's operating costs as a ratio of command's capitated budget
- * Meet or beat national comparative benchmarks in Length of Stay for targeted Diagnostic Groups
- * Control CHAMPUS expenditures by expanding use of Contracts/Partnerships to decrease the number of Non-Availability Statements (NAS)
- * Monitor compliance of Partnerships and Contractual criteria

Initiatives: Implement activity based costing management system. Implement UM Program within 12 months with medical staff involvement in outcomes measures.

GOAL 3:"WE WILL MAXIMIZE THE DELIVERY OF HEALTH CARE"

- * Meet or exceed all DOD Active Duty health care indicators
- * 95% fill rate on all available appointments
- * Maximize utilization of an alternate care system for non-hospital skilled nursing care
- * Fully computerized inpatient records

Initiatives: Establish monthly health promotion community activities with an emphasis on new program development. Implement monthly target market coverage relating to community health promotions. Research, develop, and implement a computerized inpatient record system.

GOAL 4: "WE WILL PROMOTE JOB SATISFACTION THROUGH A POSITIVE WORK ENVIRONMENT"

- * Fulfill 90% job expectations based on survey results
- * Train all staff in TQL methods and concepts

Initiatives: Establish "Quality Bill of Rights". Use Navy Achievement Medal as recognition for "Sailor of the Quarter". Establish Meritorious Service Award as recognition for "Civilian of the Month". Select from "Civilian of the Month" winners for "Civilian of the Year" and present Superior Civilian Service Award as recognition.

GOAL 5: "WE WILL PROMOTE A POSITIVE COMMAND IMAGE"

- * Improve customer satisfaction base on survey results
- * Reduce deficiencies on zone inspections
- * Increase media coverage on hospital and staff successes

Initiatives: Implement standard survey instruments that capture customer satisfaction. Re institute zone inspections for the command with emphasis on safety, aesthetics, maintenance, and repair. Media blitz targeted populations about upcoming health promotion activities, then gather consumer information at activities to determine the most effective media channels for coverage of hospital activities.

GOAL 6: "WE WILL PROMOTE THE PROFESSIONAL DEVELOPMENT, EDUCATION AND TRAINING OF ALL HOSPITAL PERSONNEL"

- * Increase professional growth and advancement
- * All Time in Rate (TIR) eligible personnel will compete for advancement
- * Initial competency review of primary skills completed within 90 days of assignment and annual review thereafter

Initiatives: Develop a position skills list for all hospital positions. Develop a policy for review and accountability (using JCAHO standards) of competent skills.

GOAL 7: "WE WILL PROMOTE COMMUNITY WELLNESS"

- * Health Promotion Department will develop one new community activity per fiscal quarter.
- * We will increase our attendance per cost ratio on health screening activities.
- * We will market to 95% of our target beneficiaries annually.

**PRODUCT LINE ANALYSIS FOR
INPATIENT PRIMARY CARE SERVICES**

CLINICAL SERVICES

Service	MEPRS Codes
Internal Medicine	AAA
Pediatrics	ADA, AGD
Family Practice	AGA, AGB, AGC, AGE, AGH

INPATIENT PRIMARY CARE SERVICES

COMPARISON OF COST DATA (MTF - Oct-Jul FY 1995/CHAMPUS - FY 1994)

Service (Number of Admissions)	MTF Inpatient Expense	Estimated Expense if CHAMPUS	Government Savings/(Loss)
Internal Medicine (313)	\$2,323,951	\$1,575,955	(\$747,996)
Pediatrics (193)	\$1,021,585	\$383,105	(\$638,480)
Family Practice (308)	\$1,136,140	\$1,605,582	\$469,442
Totals	\$4,481,676	\$3,564,642	(\$917,034)

Source: MTF - MEPRS data Oct 94-Jul 95
CHAMPUS - Healthcare Summary Report FY 1994

CONSIDERATION

Although provider salaries are included in MEPRS expense data, the majority of Inpatient Services did not show a value for those salaries. The most likely explanation is that all provider salaries were reported to Outpatient Services. Hence, total government savings for Inpatient Services may be lower than indicated.

MTF INPATIENT ADMISSIONS COMPARISON (FY 1994 and FY 1995)

Service	FY 94 Admissions	FY 95 (Oct-Jul) Admissions	FY 94 Monthly Avg	FY 95 (Oct-Jul) Monthly Avg	Monthly Increase (+) Decrease (-)
Internal Medicine	752	313	63	31	-32
Pediatrics	336	193	28	19	-11
Family Practice	620	308	52	31	-21

Source: MEPRS data FY 94 and FY 95 (Oct-Jul)

PATIENT UTILIZATION

The below listed table displays number of admissions for FY 1995 by beneficiary category:

NHC ADMISSIONS BY BENEFICIARY CATEGORY (FY 1995)

Beneficiary Category	Number of Admissions (FY 1995)	Percentage of Admissions
Active Duty	1,497	28.2%
Dep of Active Duty	1,401	26.4%
Retired and Dep of Retired	2,403	45.4%
Total	5,301	100%

Source: Navy Workload Report, 1995

**PRODUCT LINE ANALYSIS FOR
OUTPATIENT PRIMARY CARE SERVICES**

CLINICAL SERVICES

Service	MEPRS Codes
Internal Medicine	BAA
Cardiology	BAC
Neurology	BAK
Pediatrics	BDA,
Family Practice	BGA
Primary Care Clinics (PCC, NWS, Naval Sta)	BHA
Optometry	BHC
Emergency Medicine	BIA
Dental Services	CAA,
Health Promotion	EBBC
NAVCARE	BHH

OUTPATIENT PRIMARY CARE SERVICES

COMPARISON OF COST DATA (MTF - OCT-JUL FY 1995/CHAMPUS FY 1994)

Service (Visits)	MTF Outpatient Expense	Estimated Expense if CHAMPUS	Government Savings/(Loss)
Internal Medicine (5,922)	\$1,468,545	\$554,274	(\$914,271)
Cardiology (0)	0	0	0
Neurology (0)	\$37,882	0	(\$37,882)
Pediatrics (8,766)	\$1,040,543	\$827,861	(\$212,682)
Family Practice (28,214)	\$2,527,425	\$2,664,530	\$137,105
Primary Care Clinics (47,261)	\$5,842,161	\$4,463,329	(\$1,378,832)
Optometry (4,119)	\$324,191	\$388,988	\$64,797
Emergency Medicine (22,639)	\$6,911,869	\$2,138,027	(\$4,773,842)
Dental Service	\$513,027	Data Not Available	
Health Promotion	\$241,929	Data Not Available	
NAVCARE (49,097)	\$3,624,560	\$4,636,721	\$1,012,161
Totals	\$22,532,132	\$15,673,730	(\$6,103,446)

Source: MTF - MEPRS data Oct 94 - Jul 95

CHAMPUS - Healthcare Summary Report FY 1994

**AVERAGE COST PER VISIT
(Outpatient Primary Care Services)**

The data displayed below shows the average cost per visit for each service, both in the MTF and through CHAMPUS.

COMPARISON OF COST DATA (MTF - OCT-JUL FY 1995/CHAMPUS - FY 1994)

Outpatient Service (Number of Visits)	MTF Avg Cost per Visit	CHAMPUS Avg Cost per Visit	Government Savings/(Loss)
Internal Medicine (5,922)	247.98	94.44	(153.54)
Neurology (0)	N/A	103.61	N/A
Pediatrics (8,766)	118.70	94.44	(24.26)
Family Practice (28,214)	89.58	94.44	4.86
Primary Care Clinics (47,261)	123.61	94.44	(29.17)
Optometry (4,119)	78.71	94.44	15.73
Emergency Medicine (22,639)	305.31	94.44	(210.87)
NAVCARE (49,097)	73.82	94.44	20.62

Source: MTF - MEPRS data Oct 94 - Jul 95

CHAMPUS - Healthcare Summary Report FY 1994

FACTORS AFFECTING MEPRS/CHAMPUS EXPENSES

Available CHAMPUS data does not provide per visit cost for each type of primary care outpatient visit. Therefore, estimated CHAMPUS expenses are based on averages for outpatient primary care visits. CHAMPUS funded Emergency Medicine visits are probably more than \$94.44 and Pediatric visits are probably less.

MTF OUTPATIENT VISIT COMPARISON (FY 1994 and FY 1995)

Service	FY 94 Visits	FY 95 (Oct-Jul) Visits	FY 94 Monthly Avg	FY 95 (Oct-Jul) Monthly Avg	Monthly Increase (+) Decrease (-)
Internal Medicine	9,794	5,922	816	592	-224
Pediatrics	14,483	8,766	1,207	877	-330
Family Practice	47,641	28,214	3,970	2,821	-1,149
Primary Care	57,655	47,261	4,805	4,726	-79
Optometry	7,135	4,119	595	412	-183
Emergency Medicine	30,130	22,639	2,511	2,264	-247

Source: MEPRS FY 94 and FY 95 (Oct-Jul)

MTF COST PER OUTPATIENT VISIT COMPARISON (Year to Year)

Outpatient Service	FY94 Avg Cost Per Visit	FY95 Avg Cost per Visit	Increase (+)/ Decrease (-) Cost per Visit
Internal Medicine	232.05	247.98	+15.93
Neurology	278.23	N/A	N/A
Pediatrics	86.87	118.70	+31.83
Family Practice	94.98	89.58	-5.40
Primary Care Clinics	96.57	123.61	+27.04
Optometry	62.58	78.71	+16.13
Emergency Medicine	262.64	305.31	+42.67
NAVCARE	43.36	73.82	+30.46

Source: MEPRS data FY 94 and FY 95 (Oct-Jul)

CONSIDERATION

Declining demand from beneficiary population has resulted in reduced workload/productivity. However, fixed cost remain relatively constant and are spread across fewer admissions/visits, resulting in increased cost per unit of productivity.

**PRODUCT LINE ANALYSIS FOR
INPATIENT SPECIALTY SUPPORT SERVICES**

CLINICAL SERVICES

Service	MEPRS Codes
General Surgery	ABA
Ophthalmology	ABE
Oral Surgery	ABF
Otorhinolaryngology	ABG
Urology	ABK
Gynecology	ACA
Obstetrics	ACB
Orthopedics	AEA
Mental Health	AFA

INPATIENT SPECIALTY SUPPORT SERVICES

COMPARISON OF COST DATA (MTF - OCT-JUL FY 1995/CHAMPUS - FY 1994)

Service (Number of Admissions)	MTF Inpatient Expense	Estimated Expense if CHAMPUS	Government Savings/(Loss)
General Surgery (737)	\$5,774,667	\$4,732,277	(\$1,042,390)
Ophthalmology (164)	\$503,437	\$762,764	\$259,327
Oral Surgery (48)	\$244,831	\$428,592	\$183,761
Otorhinolaryngology (398)	\$1,314,550	\$2,012,288	\$697,738
Urology (324)	\$1,240,920	\$1,439,532	\$198,612
Gynecology (346)	\$1,456,554	\$1,647,998	\$191,444
Orthopedics (525)	\$3,126,369	\$4,615,800	\$1,489,431
Mental Health (113)	\$722,178	\$1,089,320	\$367,142
Totals	\$14,383,506	\$16,728,571	\$2,345,065

Source: MTF - MEPRS data Oct 94 - Jul 95

CHAMPUS - Healthcare Summary Report FY 1994

CONSIDERATIONS

Although provider salaries are included in MEPRS expense data, the majority of Inpatient Services did not show a value for those salaries. The most likely explanation is that all provider salaries were reported to Outpatient Services. Hence, total government savings for Inpatient Services may be lower than indicated.

Acuity level of admissions are not reflected in the table above. Generally, the most acute cases are provided through CHAMPUS and cause the average CHAMPUS admission cost to rise. It is likely that if the inpatient workload normally handled by the MTF were referred to CHAMPUS providers, the actual costs would be less than those estimated in the table. Hence, total government savings for Inpatient Service may be lower than indicated.

MTF INPATIENT ADMISSION COMPARISON (FY 1994 and FY 1995)

Service	FY 94 Admissions	FY 95 (Oct-Jul) Admissions	FY 94 Monthly Avg	FY 95 (Oct-Jul) Monthly Avg	Monthly Increase (+) Decrease (-)
General Surgery	1,280	737	107	74	-33
Ophthalmlogy	214	164	18	16	-2
Oral Surgery	63	48	5	5	0
ENT	567	398	47	40	-7
Urology	355	324	30	32	+2
GYN	495	396	41	35	-6
Ortho	563	525	47	53	+6
Mental Health	253	113	21	11	-10

Source: MEPRS data FY 94 and FY 95 (Oct-Jul)

PATIENT UTILIZATION

The below listed table displays number of admissions for FY 1995 by beneficiary category:

MTF ADMISSIONS BY BENEFICIARY CATEGORY (FY 1995)

Beneficiary Category	Number of Admissions (FY 1995)	Percentage of Admissions
Active Duty	1,497	28.2%
Dep of Active Duty	1,401	26.4%
Retired and Dep of Retired	2,403	45.4%
Total	5,301	100%

Source: Navy Workload Report, 1995

**PRODUCT LINE ANALYSIS FOR
OUTPATIENT SPECIALTY SUPPORT SERVICES**

CLINICAL SERVICES

Service	MEPRS Codes
Dermatology	BAP
General Surgery	BBA
Ophthalmology	BBD
Otorhinolaryngology	BBF
Urology	BBI
Gynecology	BCB
Obstetrics	BCC
Orthopedics	BEA, BEB
Mental Health	BFA, BFB,

OUTPATIENT SPECIALTY SUPPORT SERVICES

COMPARISON OF COST DATA (MTF - OCT-JUL FY 1995/CHAMPUS - FY 1994)

Service (Number of Visits)	MTF Outpatient Expense	Estimated Expense if CHAMPUS	Government Savings/(Loss)
Dermatology (5,340)	\$833,059	\$455,182	(\$377,877)
General Surgery (8,290)	\$2,103,908	\$1,866,576	(\$237,332)
Ophthalmology (4,224)	\$671,374	\$548,655	(\$122,719)
Otorhinolaryngology (3,464)	\$790,422	\$590,127	(\$200,295)
Urology (5,537)	\$995,417	\$1,401,027	\$405,610
Gynecology (5,807)	\$777,150	\$811,063	\$33,913
Obstetrics (2,367)	\$831,866	\$363,429	(\$468,437)
Orthopedics (7,609)	\$1,671,463	\$896,576	(\$774,887)
Mental Health (1,776)	\$1,069,104	\$289,956	(\$779,148)
Totals	\$9,743,763	\$7,222,591	(\$2,521,192)

Source: MTF - MEPRS data Oct 94 - Jul 95
 CHAMPUS - Healthcare Summary Report FY 1994

AVERAGE COST PER VISIT
(Outpatient Specialty Support Services)

The data displayed below shows the average cost per visit for each service, both in the MTF and through CHAMPUS.

COMPARISON OF COST DATA (MTF - OCT-JUL FY 1995/CHAMPUS - FY 1994)

Outpatient Service	MTF Avg Cost per Visit	CHAMPUS Avg Cost per Visit	Government Savings/(Loss)
Dermatology	156.00	* 85.24	(70.76)
General Surgery	253.79	225.16	(28.63)
Ophthalmology	158.94	129.89	(29.05)
Otorhinolaryngology	228.18	170.36	(57.82)
Urology	179.78	253.03	73.25
Gynecology	133.83	139.67	5.84
Obstetrics	351.44	153.54	(197.90)
Orthopedics	141.88	76.11	(65.77)
Mental Health	200.43	54.36	(146.07)

Source: MTF - MEPRS data Oct 94-Jul 95

CHAMPUS - Healthcare Summary Report FY 1994

NOTE: MTF Obstetrics data (costs) are misleading due to MEPRS reporting/recording practices. Actual costs per visit are probably less than \$351.44 per visit.

MTF OUTPATIENT VISIT COMPARISON (FY 1994 and FY 1995)

Service	FY 94 Visits	FY 95 (Oct-Jul) Visits	FY 94 Monthly Avg	FY 95 (Oct-Jul) Monthly Avg	Monthly Increase (+) Decrease (-)
Derm	7,353	5,340	613	534	-79
General Surgery	14,622	8,290	1,219	829	-390
Ophthalmgy	6,295	4,224	525	422	-103
ENT	5,983	3,464	499	346	-153
Urology	7,807	5,537	651	554	-97
GYN	12,594	2,367	1,049	581	-468
OB	12,594	7,609	1,049	761	-288
Ortho	12,632	7,588	1,053	758	-295
Mental Health	9,711	5,334	809	533	-276

Source: MEPRS FY 94 and FY 95 (Oct-Jul)

NOTE: OB and GYN outpatient visits in FY 94 were combined by MEPRS and totalled 25,128. The total was halved to provide a comparison to FY 95 data.

MTF COST PER OUTPATIENT VISIT COMPARISON (Year to Year)

Outpatient Service	FY94 Avg Cost Per Visit	FY95 Avg Cost per Visit	Increase (+)/ Decrease (-) Cost per Visit
Dermatology	121.63	156.00	+34.37
General Surgery	173.70	223.79	+50.09
Ophthalmology	116.09	158.94	+42.85
Otorhinolaryngology	160.33	228.18	+67.85
Urology	147.86	179.78	+31.92
Gynecology	111.93	133.83	+21.90
Obstetrics	111.93	351.44	+239.51
Orthopedics	137.83	141.88	+4.05
Mental Health	110.91	200.43	+89.52

Source: MEPRS data FY 94 and FY 95 (Oct-Jul)

NOTE: OB and GYN outpatient visits in FY 94 were combined by MEPRS which explains the identical average cost per visit.

FACTORS AFFECTING MEPRS EXPENSES

Declining demand from beneficiary population has resulted in decreased workload/productivity. However, fixed cost remain relatively constant and are spread across fewer admissions/visits resulting in increased costs per unit of productivity.

**PRODUCT LINE ANALYSIS FOR
ANCILLARY SUPPORT SERVICES**

CLINICAL SERVICES

Service	MEPRS Codes
Nutrition	BAL
Social Work	BFE
Audiology	BHD
Occupational Health	BHG
Physical Therapy	BLA/DHD
Occupational Therapy	BLB/DHB
Preventive Medicine	FBB
Industrial Hygiene	FBC
Radiation Health	FBD
Immunizations	FBI

ANCILLARY SUPPORT SERVICES

COMPARISON OF COST DATA (MTF - OCT-JUL FY 1995/CHAMPUS - FY 1994)

Service	MTF Expense	Estimated Expense if CHAMPUS	Government Savings/(Loss)
Nutrition	\$22,657	\$94,705	\$72,048
Social Work	\$558,000	\$63,859	(\$494,141)
Audiology	\$70,984	\$74,472	\$3,488
Physical Therapy	\$638,382	\$175,182	(\$463,200)

Source: MTF - MEPRS data Oct 94 - Jul 95
CHAMPUS - Healthcare Summary Report FY 1994

NOTE: Cost comparison for ancillary support services is limited by available data for like services from CHAMPUS.

GENERAL RECOMMENDATIONS REGARDING THE PRODUCT LINE ANALYSIS

Strive to improve MEPRS reporting, recording, and monitoring to establish a more reliable cost accounting system. Educate, inform, and train staff members on the importance of accurate reporting and provide feedback to department heads on allocated expenses.

Focus on determining the causes of the perceived inefficiencies in the military group practices, and work toward resolution of the problems.

Investigate better ways to do true cost evaluations on services provided within the MTF.

Develop/obtain data that allows an "apples to apples" comparison of like services between MTF and CHAMPUS.

Perform another Product Line Analysis after the complete FY 1995 data is available for both the MTF and CHAMPUS.

HAZARDOUS MATERIAL DISPOSAL FOR 1995

<u>Waste Description</u>	<u>Weight (lbs)</u>
Toluene	512
Nitrocellulose	1
Ammonia hydroxide	1
Trichloroacetic acid	7.4
Benzoin tincture compound	8.5
Formalin	3
Oxalic acid	1
Hydrochloric acid	2
Chloroform	1.5*
Phenol	4.5
Chlorothen solvent	4
Soldering flux	1
Paraffin napthenes	56
Grease, general purpose	2
Mineral spirits	8
Blueing reagent	71
Aerosol cans	2
Glacial acetic acid	4
Pyruvic acid	1
Thymol	1
10% Potassium hydroxide	3.2
Collodion flexible	1
Stain, fixative	190

MEMORANDUM

Jan 30, 1996

JK
From: Gene Kurtz, EMSA Project Manager, NAVHOSPCHAS
To: Public Affairs Office, Code-09PA, NAVHOSPCHAS
Subj: COMMAND HISTORY INPUT FROM THE EMSA CONTRACTOR

As requested by your office, the following information is submitted for inclusion into the Command History document to be forwarded to BUMED.

EMERGENCY DEPARTMENT:

- Visits.....27,421
- LWBS..... 551
- Triage..... 1,536
- Treated.....25,334

- Emergent Patients. 30
- Urgent Patients... 1,639

- Admissions..... 1,045
- Transfers..... 283

Length of stay averages:

	<u>Jan thru Jun</u>	<u>Jul thru Dec</u>
< two Hrs.....	56.9%	71.1%
Two to Four Hrs.....	33.1%	23.6%
Four to Six Hrs.....	8.0%	4.4%
> Six Hrs.....	2.0%	1.1%

Physician Hrs Worked.11,176
PA/NP Hrs Worked..... 5,838
RN Hrs Worked.....17,502
Support Staff.....32,701

Continuing Medical Education:

- Physicians.....658 Hrs
- PA/NP.....456 Hrs
- RN..... 60 Hrs

PRIMARY CARE CLINIC (GREEN TEAM):

- Patients Treated..21,022
- Admissions..... 31

Subj: COMMAND HISTORY INPUT FROM THE EMSA CONTRACTOR

Physicians Hrs Worked.....9,213
PA/NP Hrs Worked.....5,026
Support Staff.....21,471

Continuing Medical Education:

- Physicians..... 108 Hrs
- PA/NP..... 72 Hrs
- RN..... 10 Hrs

The Primary Care Clinic moved from a space where the physicians were sharing examination rooms. PA's/NPs' also had to share an examination room. The space in the hospital the clinic now occupies is large enough for each physician to have two examination rooms of their own, and the PAs'/NPs', each have an exam room. Patient flow and comfort has drastically improved. The staffs' stress level has decreased markedly from this move.

NAVAL HOSPITAL, CHARLESTON
11-15 SEPTEMBER 1995

DISCUSSION PAPER

SUBJECT: NURSING CARE/AMBULATORY CARE

REFERENCES: (a) Current Edition Accreditation Manual for Hospitals
(b) Local Nursing Operating Manuals
(c) NAVHOSPCHASNINST 6550.6
(d) NAVHOSPCHASNINST 6401.1H
(e) NAVHOSPCHASNINST 6460.1B

DISCUSSION:

1. Nursing care was evaluated utilizing references (a) through (e). Significant compliance was found.
2. Reference (a) requires that the nursing process be applied to all patients. Components of the process are assessment, planning, intervention and evaluation. In 10 out of 15 records reviewed evidence of the nursing process is lacking. Evaluation of nursing care, including revision and resolution of the plan, was particularly deficient.
3. Reference (a) mandates that hospitals maintain a single standard of care for all patients on all shifts with the same condition. In order to fully meet the intent of this mandate, there must be standardized policies and procedures for like patients and identical training and competency for staff who care for them. It was noted that some policies and procedures differed among the 3 Family Medicine teams. Degree and quality of training among their staff varied. Patients on SDSU and APU with similar surgical/anesthetic interventions had unequal levels of postoperative monitoring.
4. Per reference (a), all staff who provide direct care to newborn, pediatric and geriatric patients must demonstrate age specific competencies. Growth and development and safety must be a part of these competencies. The majority of both inpatient and outpatient staff who care for pediatric patients had not completed the required competencies.
5. Mechanisms must be in place to protect patient privacy. Many exam tables in ambulatory care clinics face out to the hallway. No privacy curtains are available. I observed one episode where a staff member entered a room while an exam was in progress, partially exposing a patient. In some clinics confidential medical information is displayed on racks and counters.

ASSIST TEAM MEMBER: LCDR Kathleen Warren, NC, USN
DSN/COMM 942-7864/904-772-7864

NAVAL HOSPITAL, CHARLESTON
11-15 SEPTEMBER 1995

SUBJECT: NURSING CARE/AMBULATORY CARE

RECOMMENDATIONS:

1. Assure that all steps in the nursing process are documented. Nursing has developed comprehensive yet user-friendly charting forms. I do not recommend changing them now. An assessment of the environment in which charting occurs might identify factors that hinder completion.

2. Provide a single standard of care throughout the organization.

3. Design and implement age-specific competencies. Naval Hospital Beaufort has an outstanding pediatric care training module. Naval National Medical Center has some geriatric competencies established.

4. Assure that patient privacy is protected. The stated policy is to keep room doors closed and limit entry during exams. Be certain that this policy is promulgated and consistently practiced. Consider placing signs on doors stating "Exam in progress, do not enter." Consider hanging privacy curtains, consistent with infection control practices. Do not display patient medical information in public areas.

SUPPLEMENTAL REMARKS:

1. The four topics discussed above are IG high interest items.

2. The structures, processes and implementation of nursing care have greatly improved since the last assist visit.

3. Hospital corpsmen interviewed were highly knowledgeable and committed to patient advocacy.

ASSIST TEAM MEMBER: LCDR Kathleen Warren, NC, USN
DSN/COMM 942-7864/904-772-7864



DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
CHARLESTON, SOUTH CAROLINA 29408-6900

IN REPLY REFER TO:
NHCHASNINST 6320.62D
Code 091
0 5 MAR 1992

NAVHOSPCHASNINST 6320.62D

From: Commanding Officer

Subj: QUALITY IMPROVEMENT AND ASSESSMENT PROGRAM

Ref: (a) Accreditation Manual for Hospitals, Current Edition
(b) BUMED 6010.13
(c) NAVHOSPCHASNINST 6320.75C
(d) NAVHOSPCHASNINST 5112.3E

Encl: (1) Minutes Preparation and Routing
(2) Occurrence Screen Reporting Guidance
(3) Related Instructions/References
(4) QI Information Flowchart

1. Purpose. It is the policy of this Command to have a comprehensive, ongoing system for the review and evaluation of the quality and appropriateness of medical care rendered to beneficiaries through the application of the ten-step model of the Joint Commission on Accreditation of Healthcare Organizations and identification of indicators and monitors by all departments.

2. Cancellation. NAVHOSPCHASNINST 6320.62C

3. Background. Reference (a) delineates the standards of the Joint Commission on Accreditation of Healthcare Organizations which require all participating facilities to develop and implement comprehensive ongoing Quality Improvement & Assessment Programs. Reference (b) is the Bureau of Medicine and Surgery instruction which outlines an all-inclusive, continually evolving, Quality Improvement and Risk Management Program.

4. Quality Improvement and Assessment Methodology. To obtain maximal benefit, the Quality Improvement & Assessment Program has been designed to incorporate the ten-step model of monitoring and evaluation defined by the Joint Commission on Accreditation of Healthcare Organizations. This provides a comprehensive, systematic approach to Quality Improvement, Risk Management and Utilization Review. It is a criteria-based review of patient care, both concurrent and retrospective, to identify opportunities to improve care and trends of patient care in order that corrective action can be taken when indicated. All major services provided will implement the ten-step model of Quality and monitor for trends that impact directly or indirectly on patient care as well as on areas with potential for substantial improvement in patient care. The components of the ten-step model include:

- (1). Assign responsibility
- (2). Delineate the scope of care
- (3). Identify the most important aspects of care
- (4). Establish Indicators
- (5). Establish thresholds
- (6). Collect and Organize Data

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- (7). Evaluate Care Provided
- (8). Take Actions to Improve Care
- (9). Assess effectiveness of actions taken
- (10). Communicate Results.

5. Responsibilities. All departments, clinics, and committees are to be guided in their activities by references (a) through (d) and/or their implementing instructions and submit minutes in accordance with enclosure (1).

a. General. The effectiveness of the Quality Improvement & Assessment Program is dependent upon each department or committee reviewing results of quality assessment activities particular to its area of expertise. In recognition of the interdependence of these activities and the need for coordination, guidelines are established to ensure an integrated effort toward the monitoring, evaluation, and improvement of all aspects of patient care.

b. Clinical Departments and Branch Clinics The Quality Improvement & Assessment Program is based upon a comprehensive, systematic approach to overall monitoring, with findings being reported by department heads/SMO's on a concurrent and retrospective basis for administrative and peer review. Each department head/SMO is directed to have a written departmental Quality Improvement plan to describe how the quality of inpatient and outpatient care shall be reviewed and evaluated and a staff member will be appointed to be responsible for coordinating quality improvement activities. The monitoring, review, and evaluation process shall be ongoing and involve, as appropriate.

- (1) Departmental indicators
- (2) Occurrence Screen results and review
- (3) Morbidity and Mortality

(4) Medical Staff monitor reviews, as appropriate: Drug Utilization (Therapeutic, Prophylactic, and Empiric), Blood Usage, Invasive Procedure Review, Medical Record Review, Infection Control.

(5) Risk Management review as appropriate: Administrative Occurrence Reports, Patient Satisfaction, Topics from Investigations/Inquiries, trending of Occurrence Screens.

(6) Utilization Review, as appropriate: Length of Stay, Ancillary Services.

(7) Inspection/survey/audit results

(8) Feedback from other departments/committees.

c. Ancillary Departments. Each department head is directed to have a written departmental Quality Improvement plan and appoint a staff member to be responsible for coordinating Quality Improvement activities which monitor, review, and evaluate all aspects of their services related to patient care.

d. Committees. To ensure the fullest possible degree of integration and coordination between command-wide Quality Improvement & Assessment activities, each of the below listed committees will function in accordance with its implementing instruction. Committee chairmen should confer with the Quality Improvement Department on the opportunities of improvement and will conduct overviews of patient care and studies as determined to be necessary by the Executive Committee of the Medical Staff or Quality Improvement Committee. The listing of committees is as follows:

- (1) Executive Committee of the Medical Staff
- (2) Quality Improvement/Risk Management
- (3) Invasive Procedure and Transfusion Committee
- (4) Pharmacy and Therapeutics (including Drug Utilization Review)
- (5) Infection Control
- (6) Special Care Committee
- (7) Safety Policy Committee
- (8) Medical Record Review Committee
- (9) Cardiac Arrest Committee
- (10) Other committees as directed by the Commanding Officer

e. Executive Officer. The Executive Officer is overall manager of the Command Quality Improvement & Assessment Program. The duties and functions of the position are to:

(1) Establish effective means of communication with the Quality Improvement Physician Advisor and the Quality Improvement Department for the reporting of job-related problems, administrative occurrences, patient care occurrences, and/or adverse trends of patient care.

(2) Gain full staff participation and cooperation in the Quality Improvement & Assessment Program by use of position authority.

(3) Review and approve agenda items for the Quality Improvement/Risk Management Committee meeting.

(4) Serve as Chairman of the Quality Improvement/Risk Management Committee.

f. Quality Improvement Physician Advisor. A Senior Medical Corps Officer will be appointed in writing with responsibilities to assure that the following are accomplished:

(1) Advise and assist the QI Coordinator in the administration and management of the Quality Improvement Department.

0 5 MAR 1992:

(2) Assist medical staff committees in development of indicators a: in identifying opportunities of improvement through ongoing monitors, peer review, and education.

(3) Review action plans developed by committees, departments and services.

(4) Assist in monitoring, tracking, and trending on patient care issues and occurrence screening.

(5) Assist in communicating information from review and evaluation processes and data sources to committees, departments, and persons affected.

(6) Assist in implementing actions approved by the Executive Committee of the Medical Staff and the Commanding Officer.

(7) Provide inservice for Quality Improvement programs.

(8) Serve as a member of the Quality Improvement/Risk Management Committee and the Executive Committee of the Medical Staff.

g. Quality Improvement Coordinator. A Senior Medical Department Officer (or equivalent civilian) shall be appointed in writing as Quality Improvement Coordinator who will be overall in charge of the QI department and will be responsible to assure that the following are accomplished:

(1) Assist departments and committees in the development and maintenance of Quality Improvement activities appropriate in scope and procedure to ensure valid patient care assessment. This shall include the development of ongoing monitors and the evaluation of care provided.

(2) Collect, review, and analyze committee and departmental minutes for opportunities of improvement and trends. Establish and maintain a system for the review, assessment, monitoring and storage of patient care evaluation data. The system shall include review and storage of all departmental and committee minutes and departmental and committee problems identified through activities of the Quality Improvement/Risk Management Committee and its associated committees.

(3) Provide data to the Quality Improvement/Risk Management Committee for the review of Quality Improvement activities of each department and committee. Prepare reviews and reports as directed.

(4) Assist the Physician Advisor in presenting to the Quality Improvement/Risk Management Committee areas of concern identified by Department Heads, Directors, and others which require committee review, and action. The Quality Improvement Coordinator shall additionally provide a QI Activity problem status report followed by the committee and newly identified areas of concern being followed at the department and committee level.

(5) Prepare and submit Quality Improvement studies and periodic reports as required by reference (b).

h. Risk Management Coordinator. A Risk Management Coordinator shall be appointed in writing. The Risk Management Coordinator will be responsible for the Occurrence Screening Program in addition to assuring that the following are accomplished:

(1) Assist departments in the implementation of risk management activities including but not limited to collecting, reviewing and analyzing occurrence reports, patient satisfaction questionnaires, patient complaints, consumer council reports and other data sources, as appropriate, to obtain information relative to risk detection, evaluation and prevention. (Enclosure (2) provides guidance on the completion and submission of occurrence reports).

(2) Collect information reflecting patterns of occurrences which may represent a potential hazard or indicate suboptimal patient care.

(3) Review and present administrative issues with potential risk management implication for proactive risk management.

(4) Establish and maintain a system for the assessment, monitoring, and storage of patient care evaluation data.

(5) Review all incidents and department activity logs to identify potential risk management problems.

(6) Prepare and submit Risk Management review studies and other periodic reports with results of the tracking and trending of ongoing monitors.

(7) Implement Occurrence Screening collection and tabulation of monthly and quarterly data and provider data as outlined in the reference (c).

(8) Develop and maintain a Risk Management Plan (Policy and Procedure Manual) which outlines the Risk Management Program in detail.

i. Utilization Review Coordinator. A Utilization Review Coordinator shall be appointed in writing and shall perform review functions and data collection for the Utilization Review Program. and the following:

(1) Establish and maintain a system to identify non-effective utilization of hospital resources reflected through inappropriate admission, prolonged hospitalization and inappropriate use of hospital ancillary services.

(2) Perform concurrent and retrospective studies and continued stay reviews and report to the Quality Improvement/Risk Management Committee any patterns of patient care reflecting ineffective utilization of hospital resources or suboptimal patient care.

(3) Develop and maintain a Utilization Review Plan (Policy and Procedure Manual) which outlines the Utilization review Program in detail.

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j. Legal Officer. The Legal Officer shall be responsible for providing legal interpretation and support to the Quality Improvement Department. That support will consist of reviewing significant incident cases referred by the QI department for potential liability and for recommending the initiation of an investigation as appropriate. Additionally, the Legal Officer shall provide advice to the Quality Improvement/Risk Management Committee in regard to potential government liability.

k. Executive Committee of the Medical Staff. The Executive Committee of the Medical Staff (ECMS) is the Senior medical staff committee monitoring all activities of Clinical Departments, Ancillary Departments, and Medical Staff Committees. The members are appointed by the Commanding Officer and will include all directors who are members of the medical staff plus one elected additional member from each directorate. The ECMS meets at least monthly and at the call of the chairman. The ECMS shall:

(1) Be empowered to act for the medical staff in the interval between medical staff meetings.

(2) Receive and act upon reports and recommendations from medical staff committees, clinical departments, and the Credentials Committee.

(3) Review concerns and recommended courses of action submitted by Departments, Clinical and Administrative Directorates and Medical Staff committees.

(4) Make recommendations for presentation to the Commanding Officer regarding appropriate courses of action.

(5) Implement the policies and procedures approved by the Commanding Officer which apply to the medical staff.

(6) Order reviews, studies, or ongoing monitors to be conducted by departments/subordinate committees as necessary for problem assessment, resolution, tracking, and trending.

(7) Provide the mechanism for medical staff accountability to the Commanding Officer for the quality of medical care delivered to patients in the hospital as monitored by the Quality Improvement/Risk Management Program, including: Invasive Procedure Review, Medical Record Review, Blood Utilization Review, Pharmacy and Therapeutics Review, Drug Usage Evaluation, Safety, Infection Control, and Quality Improvement/Risk Management.

(8) Oversee the credentials review function by the Credentials Committee and make recommendations to the Commanding Officer on all matters considered by the Credentials Committee.

(9) Review directorate and medical staff committee minutes.

(10) Pursue corrective actions when directed by the Commanding Officer in accordance with governing instructions.

(11) Prepare and Review annually, the Medical Staff Bylaws, Policies & Procedures, (reference (d)).

1. Quality Improvement/Risk Management Committee. The Quality Improvement/Risk Management Committee is the top management decision-making body for high level resolution of multidisciplinary problems and monitoring the effectiveness of the overall Quality Improvement Program.

(1) Membership. The Executive Officer shall be chairman of the Quality Improvement/Risk Management Committee. The committee shall be composed of members appointed by the Commanding Officer to include senior Directorate representatives (DFA, DNS, DMS, DAS, DSS, DOH); Elected directorate representatives; Quality Improvement Physician Advisor; Quality Improvement Coordinator; Chairman, ECMS; Risk Management Coordinator (Ad hoc); Head, Legal Department (Ad hoc).

(2) Responsibilities:

(a) Investigate concerns and direct responsible parties to implement actions.

(b) Use delegated authority in directing medical and clinical staff and committees to complete investigations at specified times.

(c) Recommend priorities for both investigating and resolving adverse trends noted in ongoing monitors.

(d) Identify the cause of problems or adverse trends and recommend appropriate high level corrective actions.

(e) Ensure that adequate follow-up occurs to evaluate the effectiveness of recommended actions.

(f) Require the involvement of all services and departments in Quality Improvement activities.

(g) Assure the highest possible quality of patient care through peer review analysis of ongoing monitors, and review and evaluation of clinical practices and support services throughout the command.

(h) Assure that findings are disseminated to appropriate individual departments and committees.

(i) Direct the conducting of focused reviews of departments and services when indicated.

6. Glossary of Terms and Related References.

a. A glossary of terms used in Quality Improvement is available in reference (b)

b. Enclosure (3) provides a handy reference list of Naval Hospital Charleston instructions which are closely related to the Quality Improvement

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Program.

c. Enclosure (4) is a Hospital QI information flowchart.

7. Annual Review. This QI/RM Plan shall be reviewed and modified by the QI Department with recommendations presented to the Commanding Officer on an annual basis. The annual QI Assessment required by reference (b) shall be completed and submitted per instruction.

8. Quality Improvement Confidentiality. Quality Improvement documents contain information **EXEMPT FROM MANDATORY DISCLOSURE** under the Freedom Of Information Act as it relates to internal practices of the Department of the Navy. Quality Improvement Documents are considered internal communications within the command. Exemptions 5 and 6 apply. These documents are not releasable, nor may their contents be disclosed outside the original distribution, nor may they be reproduced in whole or in part without the prior written approval of the Commanding Officer (or Commander Senior to the Commanding Officer) or a Judge Advocate.

9. Action. Directorates, department heads, committee chairmen, and Branch Clinic Senior Medical Officers are directed to familiarize themselves and their staffs with the contents of this instruction. It is further directed that each department, Branch Clinic, and committee develop and maintain a Quality Improvement Program for their area of responsibility utilizing the methods and guidelines provided by this instruction.


for D. E. MORTON

DISTRIBUTION:
(NHCHASNINST 5215.1F)
Lists I, III, and XII

MINUTES PREPARATION AND ROUTING

Attachment: (1) Minute Submission Requirements
(2) Endorsement/Action Sheet
(3) Format for Documenting Minutes

1. BUMEDINST 6010.13 directs the Commanding Officer to establish a standardized format and routing system to ensure appropriate dissemination of information and problem resolution. The information in attachments (1), (2), and (3) will ensure that information developed in departmental/medical staff monitor committees will be recorded, adequately shared with appropriate staff members, departments, committees, and administration for the complete integration/coordination of the Command Quality Improvement Program.

2. Minutes Preparation and Routing.

a. Each Group or committee listed in attachment (1) is responsible for conducting meetings documenting the review and evaluation of the quality and appropriateness of care as well as aspects of hospital management at specified levels. The Commanding Officer delegates approval authority of selected minutes as indicated in attachment (1). The ECMS and the QI/RM Committee will share information by way of information copies of each committee's meetings.

b. All components will route minutes in accordance with attachment (1) by the tenth day of the following month. A copy of the minutes will be maintained by the minutes originator.

c. The Quality Improvement Coordinator is responsible for the attachment of the endorsement/action sheet to the original minutes and for the routing of the minutes as indicated by attachment (1).

(1) The originator will forward the original minutes directly to the Quality Improvement Department. After review, a copy of the completed endorsement/action sheet (attachment (2)) will be returned to the minutes originator for appropriate action, follow-up and preparation for the next meeting.

(2) The Quality Improvement Coordinator will maintain the original minutes with the original completed endorsement/~~action~~ sheet attached. These minutes will be maintained for a minimum of three years.

d. Components with delinquent minutes will be referred to the Executive Officer, Head of the Directorate, or Head of the ECMS for appropriate action.

e. Attachment (3) illustrates the standard format for the documentation of minutes, and minutes which are not prepared/submitted in proper format will be returned to the originator for correction.

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**MINUTES SUBMISSION REQUIREMENTS
SPECIAL FUNCTION COMMITTEE REQUIREMENTS**

COMMITTEE	REPORTING FREQUENCY	REVIEWERS	NOTES
<u>Occupational Health Directorate</u>			
Director, Occ. Health	Monthly	A	1,2
Preventive Medicine	Monthly	G	1,2,3
Radiation Health	Monthly	G	1,2,3
Industrial Hygiene	Monthly	G	1,2,3
Occupational Health	Monthly	G	1,2,3
<u>Hospital Special Function</u>			
Command QI/RM	Monthly	E	1,2,4
ECMS	Monthly	D	1,5
Credentials	Monthly	F	1
Medical Staff	Monthly	D	1,2
<u>Hospital Wide Functions</u>			
Disaster Preparedness	PRN	D	1,2
F.A.S.T./F.A.C.	Bi-monthly	E	1,2
Health Care Consumers' Council	Quarterly	D	1,2
Occ. Safety & Health Committee	Monthly	OSH Policy Council	1
Occ. Safety & Health Council	Quarterly	D	1,2
Patient Contact	Monthly	D	1,2
<u>Medical Staff Functions</u>			
Bioethics Review	Monthly	C	1,2
Cardiac Arrest	Quarterly	C	1,2
Graduate Medical Ed.	Quarterly	F	1
Invasive Procedures & Transfusion	Monthly	C	1,2
Medical Record Committee	Monthly	C	1,2
Pharmacy & Therapeutics	Monthly	C	1,2
Infection Control	Bi-monthly	C	1,2
Special Care	Quarterly	C	1,2
Protection of Human Subj.	Annually/PRN	F	1

REVIEWERS:

- 'A' = QI---- ECMS---- XO-- CO
- 'B' = QI---- Directorate
- 'C' = QI---- ECMS
- 'D' = QI---- XO----- CO
- 'E' = XO---- CO
- 'F' = ECMS-- XO----- CO
- 'G' = QI---- Nursing- Directorate

NOTES:

- Unresolved Medical Staff QA issues will be reviewed by the ECMS and all other issues will be reviewed by the QA/RM committee.
- QA/RM is responsible for the attachment of the endorsement/action sheet to the minutes and routing the minutes as noted.
- Present summary of departmental meetings on Minute Review Sheet. This is to be enclosure to departmental minutes.
- Copy to Executive Committee of the Medical Staff.
- Copy to Command Quality Assurance/Risk Management Committee.

MINUTES SUBMISSION REQUIREMENTS
DEPARTMENT REQUIREMENTS

DEPARTMENT	REPORTING FREQUENCY	REVIEWERS	NOTES
<u>Administrative Directorate</u>			
Director, Administration	Monthly	D	1,2
Food Management	Monthly	B	1,2,3
Education and Training	Monthly	B	1,2,3
Operational Management	Monthly	B	1,2,3
Facilities Management	Monthly	B	1,2,3
Fiscal	Monthly	B	1,2,3
Management Information	Monthly	B	1,2,3
P.O.M.I.	Monthly	B	1,2,3
Patient Administration	Monthly	B	1,2,3
Materials Management	Monthly	B	1,2,3
Manpower Management	Monthly	B	1,2,3
<u>Strategic Planning Directorate</u>			
Director, Strategic Planning	Monthly	D	1,2
Data Administration	Monthly	B	1,2,3
Market Analysis	Monthly	B	1,2,3
Alternate Care	Monthly	B	1,2,3
<u>Nursing Directorate</u>			
Director, Nursing Svc	Monthly	D	1,2
<u>Medical Directorate</u>			
Director, Medical Svc	Monthly	A	1,2
Dermatology	Monthly	G	1,2,3
Emergency Medicine	Monthly	G	1,2,3
Family Practice	Monthly	G	1,2,3
Internal Medicine	Monthly	G	1,2,3
Pediatrics	Monthly	G	1,2,3
Mental Health	Monthly	G	1,2,3
ARS	Monthly	G	1,2,3
Optometry	Monthly	G	1,2,3
Branch Cl, NAVSTA	Monthly	G	1,2
Branch Cl, NAVWEAPSTA	Monthly	G	1,2
<u>Surgical Directorate</u>			
Director, Surgical Svc	Monthly	A	1,2
Anesthesia	Monthly	G	1,2,3
Dental	Monthly	G	1,2,3
Otolaryngology	Monthly	G	1,2,3
OB/GYN	Monthly	G	1,2,3
Ophthalmology	Monthly	G	1,2,3
Orthopedics	Monthly	G	1,2,3
General Surgery	Monthly	G	1,2,3
Urology	Monthly	G	1,2,3
PT/OT	Monthly	G	1,2,3
<u>Ancillary Directorate</u>			
Director, Ancillary Svc	Monthly	A	1,2
Laboratory	Monthly	B	1,2,3
Pharmacy	Monthly	B	1,2,3
Radiology	Monthly	B	1,2,3
Social Work	Monthly	B	1,2,3

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DATE _____

From: Quality Improvement/Physician Advisor
To:

Subj: MINUTES OF _____
MEETING FOR _____

1. Forwarded with/without comments.

2. Comments: _____

QI Coordinator/Date

Physician Advisor/Date

From:

To:

1. Forwarded with/without comments.

2. Comments: _____

Signature

Date

From:

To:

1. Forwarded with/without comments.

2. Comments: _____

Signature

Date

From:

To:

1. Approved/Disapproved-With/without comments.

2. Comments: _____

Signature

Date

Return to QI

05 MAR 1992

FORMAT FOR DOCUMENTING DEPARTMENTAL MINUTES

5050

Code

Date

From: Head of Department
To: See NHCHASNINST 6320.62C
Via: See NHCHASNINST 6320.62C

Subj: Minutes of the _____ (title) _____ for the month of ____ 19__.

Encl: (1) Attendance Matrix
(2) Problem Status Report
(3) Problem Referral Report, NHCHASN 6320/29 (Rev 12/87),
if applicable
(4) Occurrence Screen Report, if applicable

1. The meeting was held on (date) at (time) with (chairperson) presiding.

2. Old Business (Previously discussed items that need further discussion/feedback/review based on the previous month's minutes, endorsement/action sheet and problem status report. Review previously identified problems by problem number).

- a. Number
- b. Brief description/discussion/summarize
- c. Conclusion: What does this mean, what are the implications
- d. Recommendations: What shall we do/plans
- e. Actions: What was done/corrective action taken, responsible party, or referral to directorate.
- f. Follow-up: What is the effect of what we did/did it improve things (reevaluation after a period of time). Is the item pending/open/resolved/closed?

Note: (Information also needs to be summarized on the Problem Status Report)

3. New Business (Discussion of newly identified item or problems)

a. Scope of Practice for this department.

(1) Volume Indicators (Report on statistical data collected by department/service and trends or serious problems apparent after review of data).

(2) Inpatient Occurrence Screens (Referrals from QA Dept)

(a) Description of occurrence and discussion (findings - what did we find/summarize)

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(b) Conclusions: What does this mean/implications

(c) Recommendations: What shall we do/plans

(d) Actions: What was done - by whom

(e) Follow up: what is the effect of what we did/did it improve things (reevaluate after a period of time - may need to assign a problem number for tracking purposes and determine next review date).

(3) Department Specific Outpatient Occurrence Screens (includes Nursing Unit screens if there is RN in clinic)

(a) Description of occurrence and discussion (findings - what did we find/summarize results of departmental trending).

(b) Conclusions: What does this mean/implication

(c) Recommendations: What shall we do/plans

(d) Actions: What was done - by whom

(e) Follow up: What is the effect of what we did/did it improve things (reevaluate after a period of time - may need to assign a problem number of tracking purposes and determine next review date).

(4) Morbidity Review (Cases of special interest or atypical cases)

(a) Description and discussion (summarize)

(b) Conclusions

(c) Recommendations

(d) Actions

(e) Follow up

(5) Focused Review Results

(a) Description of review performed with criteria/indicators used and discussion (findings - what did we find/summarize)

(b) Conclusions: What does this mean/implications

(c) Recommendations: What shall we do/plans

(d) Actions: What was done - by whom

(e) Follow up: What is the effect of what we did/did it improve things (reevaluate after a period of time - may need to assign a problem number for tracking purposes and determine next review date).

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(6) Departmental Drug Usage Evaluations (includes referrals from P & T)

(a) Description of review performed with criteria/indicators used and discussion (findings - what did we find/summarize)

(b) Conclusions: What does this mean/implications

(c) Recommendations: What shall we do/plans

(d) Actions: What was done - by whom

(e) Follow up: What is the effect of what we did/did it improve things (reevaluate after a period of time - may need to assign a problem number for tracking purposes and determine next review date).

(7) Departmental Medical Record Review (a review for clinical pertinence, adequacy of information, and referrals from Med Rec Committee). (Includes Nursing Component of Record Review if there is RN in the clinic)

(a) Description of review performed and discussion (findings - what did we find/summarize)

(b) Conclusions: What does this mean/implications

(c) Recommendations: What shall we do/plan

(d) Actions: What was done - by whom

(e) Follow up: What is the effect of what we did/did it improve things (reevaluate after a period of time - may need to assign a problem number for tracking purposes and determine next review date).

(8) Blood Usage Review (Review of any/all blood usage by the department/services, includes referrals from Invasive Procedures & Transfusion Committee)

(a) Description and discussion (findings - what did we find - summarize)

(b) Conclusions: What does this mean/implications

(c) Recommendations: What shall we do/plans

(d) Actions: What was done - by whom

(e) Follow up: What is the effect of what we did/did it improve things (reevaluate after a period of time - may need to assign a problem number for tracking purposes and determine next review date).

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(9) Surgical Case Review (Review of any/all invasive procedures performed in the department/services, includes referrals from Invasive Procedures & Transfusion Committee)

(a) Description and discussion (findings - what did we find/summarize).

(b) Conclusions

(c) Recommendations

(d) Actions

(e) Follow up

(10) Nursing Service Reviews (Standards of Practice review if RN in the clinic)

(a) Description and discussion (summarize).

(b) Conclusions

(c) Recommendations

(d) Actions

(e) Follow up

b. Hospital - Wide Monitors (referred to department for review/comment, includes Risk Management issues)

(1) Infection Control Review

(a) Description and discussion (summarize)

(b) Conclusions

(c) Recommendations

(d) Actions

(e) Follow up

(2) Management Variance Reports (incident reports)

(a) Description and discussion (summarize)

(b) Conclusions

(c) Recommendations

(d) Actions

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(e) Follow up

(3) Patient Compliments/Complaints (discuss significant patient compliments/complaints which are handled within the department/service)

(a) Description and discussion (summarize)

(b) Conclusions

(c) Recommendations

(d) Actions

(e) Follow up

(4) Safety Issues (briefings, clinic equipment, emergency equipment, & emergency code drill)

(a) Description and discussion (summarize)

(b) Conclusions

(c) Recommendations

(d) Actions

(e) Follow up

(5) Administrative Issues

(a) Education and Training (CME's, etc)

(b) Clinic administration issues (policies, procedures, instructions)

(c) Announcements/discussion of items not related to QA/RM/UR.

(d) Explanation of members 'excused' or 'represented.'

4. Items for Directorate Attention

Use this section to "flag" items which the department wants to bring to the attention of the Director or higher command attention.

Recommended action will be submitted as an enclosure utilizing the following format for each recommendation.

Problem

Brief discussion

Specific action recommended

NHCHASNINST 6320.62D
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Concur / Do not Concur / Concur with comments

Director signature

****NOTE**** The Director will be responsible for ensuring identified problems are appropriately referred.

5. Adjournment

6. Next meeting scheduled

Signature

OCCURRENCE SCREEN REPORTING GUIDANCE

Attachments: (1) Occurrence Screening Checklist NHCHASN 6320/125 (REV 3-91)
(2) Administrative Occurrence Screen (Management Variance Report), NHCHASN 6320/42 (NEW 10-89)
(3) Quality Improvement Department Statement of Concern NHCHASN 6320/201

1. Purpose. To establish a standardized reporting system designed to document unusual events, accidents, or circumstances, the following guidance is provided.

2. Definition. An occurrence is defined as 'an individual episode of harm or potential harm', or 'an expression of dissatisfaction by patients, visitors or staff'. Reporting of such events is the primary element of the Risk Management System. As such, the report is chiefly concerned with identifying the element of risk inherent in a complex medical center and is the principal form through which risk is identified and risk-reducing methods are devised.

3. System Objectives.

- a. Provide Quality Improvement/Risk Management program input.
- b. Provide factual documentation of accidents or unusual events.
- c. Provide standard reporting forms.

4. Procedures. Attachment (1) is the form to be used at this hospital for reporting patient care related events. Attachment (2) is the form to be used for reporting non-patient care events. Attachment (3) is the form to use when identifying a potential QI issue related to patient care. When completing these forms, staff members should be aware of the following:

a. Individuals initiating Reports must record factual, specific and complete information. Opinion, conjecture, and editorial comment should not be reported.

b. To reduce the possibility of duplicative or conflicting reports, only an original of attachments (1), (2) or (3) shall be completed and forwarded to the Risk Management Coordinator, Quality Improvement Unit. No copies are to be made by the originator or any reviewing individual. Due to the sensitive nature of some material reported, ensure that the reports are handled expeditiously and not left unattended.

c. Occurrence Screening Checklists, Administrative Occurrence Screens (Management Variance Reports) or Quality Improvement Department Statement of Concern forms are to be completed only by Naval Hospital staff. Under no circumstance should these forms be given to visitors or patients.

d. Attachments (1), (2) and (3) are internal working documents and must not become a part of the patient treatment record. When an event occurs that involves a patient, the medical record will simply document the occurrence, factually stating what action was taken in relation to the event. No mention should be made of the intention to file, or existence of the report.

e. Occurrence Screening Checklists, Administrative Occurrence Screens (Management Variance Reports) or Quality Improvement Department Statement of Concern forms should reach the RM Coordinator within 24 hours or the next working day if the event occurs on a weekend or a holiday.

f. Whenever a significant event is reported, additional investigation may be required. If required, additional investigation will be directed by the Commanding Officer or his designated representative.

g. The confidentiality of these reports must be maintained. Occurrence Screening Checklist, Administrative Occurrence Screens (Management Variance Reports) or Quality Improvement Department Statement of Concern forms will be filed in a secured file by the RM Coordinator.

5. Reporting:

a. Patient care related events to be reported utilizing the Occurrence Screening Checklist (attachment 1) include, but are not limited to the following:

- (1) Any accident involving a patient.
- (2) Hospital injury incurred secondary to a diagnostic, procedure or treatment error (e.g., x-ray burns, broken teeth, cuts, pressure sores from cast).
- (3) Adverse reactions to medications, transfusions, or anesthetics.
- (4) Medication errors (e.g., wrong patient, wrong medication, wrong dose, wrong frequency, wrong route of administration, or missed doses).
- (5) Blood, blood component, intravenous or intravenous 'piggy back' therapy errors (wrong patient, medication, dose, or rate).
- (6) Cancelled or repeated diagnostic procedure resulting from improper preparation of patient by the staff, technician error, or equipment failure.
- (7) Equipment breakdown or malfunction resulting in actual or potential harm to the patient.
- (8) Significant expression of dissatisfaction by the patient or 'significant other' that the patient has in some manner been slighted, neglected or mistreated.
- (9) Serious complaints about delays within the hospital system or any of its clinics.

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(10) Hint of legal action or threat of malpractice suit by patient or 'significant other'.

(11) Actual or attempted suicide.

b. Non-patient care related events to be reported utilizing the Administrative Occurrence Screen (Management Variance Report) (attachment 2) include, but are not limited to the following:

(1) Accident or unusual event occurring to a visitor, staff member (civilian or military) or private contractor, e.g. fall, injury or staff needle stick, etc.

(2) Manpower related, e.g. workload greater than personnel available, manpower mix, etc..

(3) Facility related, e.g. vehicle/transportation problem, infectious or non-infectious waste problem, building problem, i.e. leaks, broken doors, elevators, etc..

(4) Operating Management related, e.g. pager system, copier problems, guardmail system, etc..

(5) Material Management related, e.g. supplies not in stock (that do not directly impact on patient care), equipment malfunction (non-patient care equipment), etc..

(6) Patient Administration related, e.g. medical record unavailable/lost, diagnostic 'chits' not filed in chart, admission related problem (where patient care was not adversely affected), etc..

c. For staff member who believes there is a potential QI/RM issue which has not been addressed or caused an actual occurrence can utilize the Quality Improvement Department Statement of Concern form. This includes, but are not limited to the following:

(1) Any procedure or process currently in use at the Naval Hospital which may cause patient injury.

(2) To identify opportunities to improve patient care.

(3) Identify shortages of resources needed to maintain acceptable standards of patient care.

(4) Identify educational and training needs related to patient care.

(5) Any situation which may present possible negative patient care.

6. Analysis. The RM Coordinator shall perform statistical analysis of all reported accidents and unusual events. All reports, related information, follow-up documentation or investigations shall be retained by the RM Coordinator in a central confidential file.

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PROBLEM NUMBER	SUBJECT	CRITERIA	ACTION	EXPECTED DATE OF RESOLUTION	FOLLOW-UP 1
-------------------	---------	----------	--------	--------------------------------	-------------

Departments/Branch Clinics/Committees

Problem Identification/Prioritization: Once a problem has been identified, it must be prioritized according to the degree of adverse impact on patient care and tracked to resolution. Committees and groups responsible for quality assurance activities will identify and prioritize problems in the following manner:

EXAMPLE: 8810-ORTHO-001-(2)

- 88 - The year
- 10 - The month problem can be found originally described in minutes of originator
- ORTHO - Brief description of department or committee
- 001 - Consecutive number of the problem for the calendar year
- (2) - Priority, using a scale of 1 to 5 with 1 having the highest degree of adverse impact on patient care and 5 having the lowest.

ATTENDANCE MATRIX, _____ COMMITTEE, 19__

MEMBERS :	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
-----------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

P-PRESENT E-EXCUSED R-REPRESENTED *NO MTG
A-ABSENT T- TAD LV-LEAVE

List by name, directorate represented, etc.

eg. LCDR J. Doe
Surgical directorate

or CDR J. Smith
Chairman

or EMC C. Forte

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Administrative Occurrence Screen
(Management Variance Report)
NHCHASN 6320/42 (NEW 10-89)

Do not use to report PATIENT CARE
Accidents or Events

PREPARE ORIGINAL ONLY

Person Involved in Event	Name	Address		City/State	Age	Sex
	SSN	Military Status		Duty Station		
	Home Telephone #		Work Telephone #			
D E S C R I P T I O N O F U N U S U A L E V E N T	Date	Time	Area where event occurred		Exact location	
	Fully Explain Circumstances Surrounding Reportable Event: (include model #, serial # and property # for equipment)					
	Person Preparing Report	Name of Person Preparing Report			Telephone No.	Date
Signature of Person Preparing Report			GRADE/RANK/TITLE			

Purpose: When completed properly this form provides an effective method of reporting non-patient care events to the Risk Management Coordinator, Legal Department, and Commanding Officer.

Confidentiality: This report is for internal hospital use and is not to be reproduced.

Who Should Complete Report: Staff member most closely associated with the events reported.

Forwarding of Completed Report: Once completed, IMMEDIATELY forward the report to the QA/RM department for processing.

Witness Observing Event	Name	Telephone No.
	Home Address	City/State/Zip

COMMENTS OF INDIVIDUAL ASSIGNED TO EVALUATE ACCIDENT OR UNUSUAL EVENT			
PROBLEM IDENTIFIED			
ACTION TAKEN			
Name/Rank of Individual Evaluating Event		Signature	Date

Return the completed form to the Risk Management Coordinator, DO NOT ROUTE

1. Department Head	_____	Date	_____	2. Director *	_____	Date	_____
3. RM Coordinator	_____	Date	_____	4. Legal *	_____	Date	_____
5. XO *	_____	Date	_____	6. CO *	_____	Date	_____

* if necessary by circumstances or assigned priority

QUALITY IMPROVEMENT RELATED INSTRUCTIONS/REFERENCES

1. NHCHASNINST 1520.4A - Command Orientation for Newly Reporting Personnel
2. NHCHASNINST 1601.7C - Guidelines for Utilization and Credentialing of Physicians Assistants
3. NHCHASNINST 5100.1E - Occupational Safety and Health Program Manual
4. NHCHASNINST 5101.3B - Cardiac Arrest Procedures
5. NHCHASNINST 5112.3E - Medical Staff Policies and Procedures
6. NHCHASNINST 5211.1B - Release of Patient Information
7. NHCHASNINST 5420.1E - Invasive Procedure and Transfusion Committee
CH-2
8. NHCHASNINST 5420.2C - Establishment and Functions of Bioethics Review Committee
9. NHCHASNINST 5420.3A - Accreditation (Joint Commission & I.G. Planning) Committee
10. NHCHASNINST 5420.4B - Health Care Consumer Council
11. NHCHASNINST 5830.1B - Medical - Legal Investigations
12. NHCHASNINST 6010.1A - Guidelines for Administrative Management of Patients
CH-6
13. NHCHASNINST 6010.5C - Patient Regulations and Information
CH-1
14. NHCHASNINST 6220.1G - Committee Function and Guidelines for Infection Control
CH-1
15. NHCHASNINST 6230.2A - Program for Protection of Health Care Workers from Occupational Exposure to Hepatitis B Virus (HBV) Human Immunodeficiency Virus (HIV) and other blood-borne Infectious Agents.
16. NHCHASNINST 6320.11D - Credentialing Program
CH-1
17. NHCHASNINST 6320.15C - Medical Records Committee
18. NHCHASNINST 6320.19 - Advance Medical Care Directives
19. NHCHASNINST 6320.75C - Occurrence Screening
20. NHCHASNINST 6401.1H - Special Care Units

21. NHCHASNINST 6460.1 - Same Day Surgery
CH-1
22. NHCHASNINST 6460.4A - Informed Consent for Administration of Anesthesia
CH-1 Performance of Operations, and Other Procedures
23. NHCHASNINST 6570.2 - Membership and Function of the Pharmacy and
Therapeutics Committee
24. NHCHASNINST 6710.3 - Adverse Drug Reaction Reporting
- * * * * *
25. BUMEDINST 6010.13 - Quality Assurance Program
26. BUMEDINST 6320.66A - Credentials Review & Privileging Program
(Credentials Review Process)

QUALITY IMPROVEMENT DEPARTMENT STATEMENT OF CONCERN

This form is a communication device of the Quality Improvement (QI) Department for the sole purpose of identifying potential QI issues related to patient care. This information is strictly confidential and is only to be used in the confines of the QI program. This is not an occurrence or incident report. Any justifiable occurrence or incident identified will be appropriately peer reviewed.

Department/Physician

Date _____

Patient Name

Medical record number

Statement of Concern: _____

Do you feel this requires futher review? (circle one) yes no

Response and Action: _____

Signature

Date _____

PEER REVIEW INSTRUMENT - Privileged Work Document

Section II - To be Completed By QI Coordinator, Risk Manager or Physician Advisor to Quality Improvement
(Comment required to justify no further review)

Signature: _____ Date: _____ REQUIREMENT FOR FURTHER REVIEW
YES _____ NO _____

Section III: Initial review documentation

Signature _____ Date: _____

Section IV - Department Head Comments: (Hd, FP Dept must review all Category III & IV involving FP residents)

Circle one: 0 I II III IV** EXCEPTION***

Responsible Provider _____

Signature: _____ Date: _____ Dept. Index: _____

Directorate Comments:

Circle one: 0 I II III** EXCEPTION***

provider required
*** = Must be predetermined

Signature: _____ Date: _____

Credentials Committee Review and Disposition: _____ Date: _____

OCCURRENCE SCREENING CHECKLIST

WARD: _____

SERVICE: _____

CRITERION	Criteria Number	Meets an Exception	Category
1. READMISSION WITHIN 30 DAYS.			
2. ADMISSION FOR DETERIORATION OF CONDITION DURING OUTPATIENT CARE			
3. ELEVATION OF CARE, ROUTINE TO SPECIAL CARE UNIT/FACILITY.			
4. ORGAN DETERIORATION/FAILURE NOT PRESENT ON ADMISSION.			
5. RETURN TO THE OR - REPEAT INVASIVE DIAGNOSTIC PROCEDURE, SAME ADMISSION.			
6. OPERATIVE OR ANESTHETIC COMPLICATIONS.			
Naval Hospital Charleston Specific Interest items:			
7. HOSPITAL/OUTPATIENT CLINIC INCURRED EVENT			
8. NOSOCOMIAL INFECTION.			
9. DEATH			
10. OTHER, please describe below:			

Describe Occurrence completely: (include model #, Serial # and Property # for equipment related events)

PRINT Name, Grade, Title of Person Preparing Report	Signature		Date
	Date	Time	Exact Location of Occurrence
Patient Identification:	Attending Practitioner(s) (include identified residents)		

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7. Risk Management and Patient Relations. Each event must be evaluated individually to determine necessary action. The actions taken immediately after an accident or unusual event may be more significant in the eyes of the patient than the event itself. At a minimum, the event must be evaluated with the following points in mind:

a. Determine whether an explanation to the patient or family is necessary and, if so, how it will be accomplished.

b. When an injury to the patient is involved, a careful explanation to the patient is almost always the best course of action. To avoid the issue only makes matters worse.

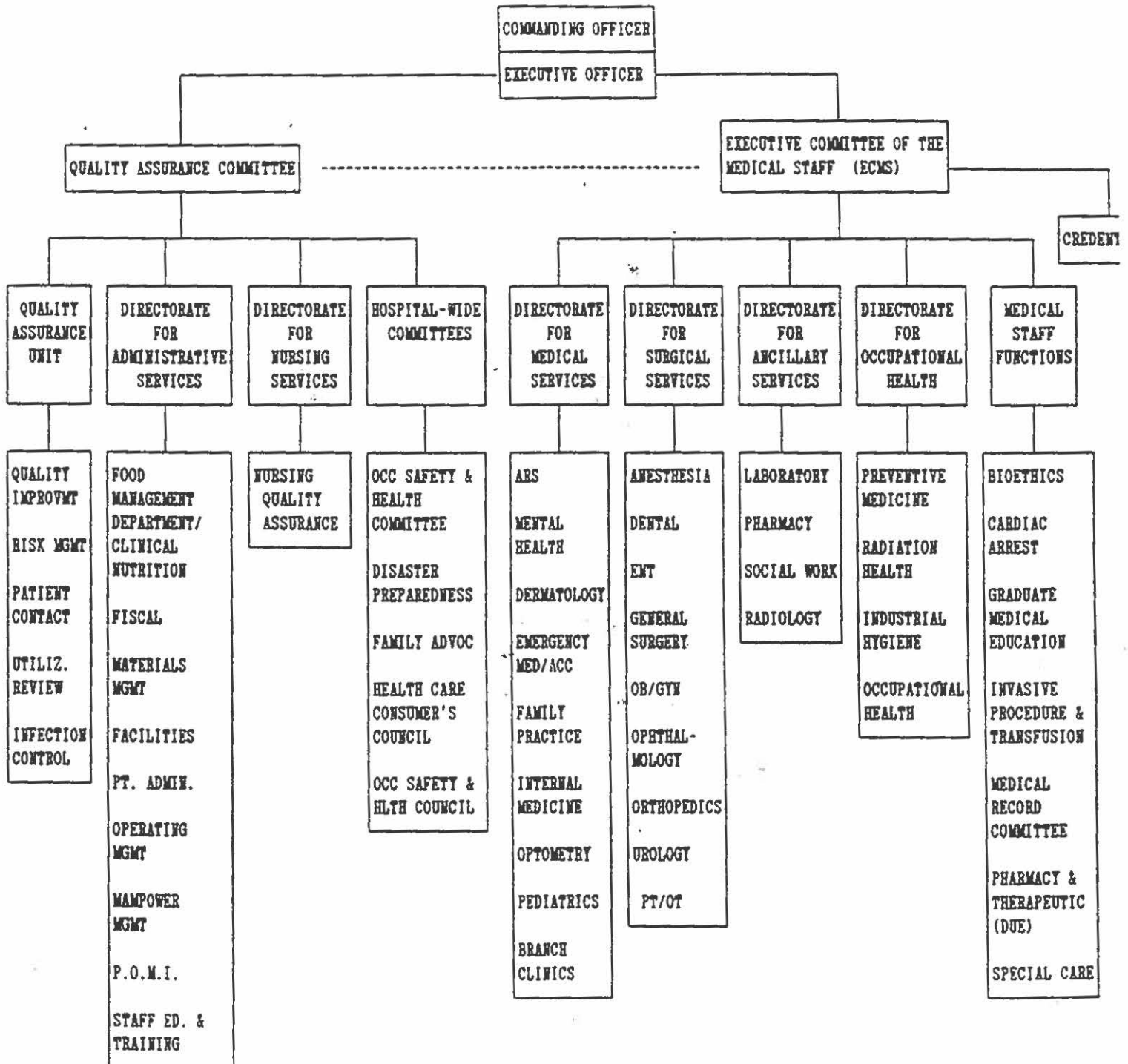
c. The explanation to the patient should be provided by the person most qualified and most knowledgeable about the event.

d. If the patient is unaware of the event and if it does not cause injury to the patient or affect the medical care provided, there should be no reason to alarm the patient.

e. Careful documentation of the event together with the explanation provided to the patient, must be accomplished.

f. Whenever personal injury is involved, it is mandatory that the person receive medical attention. Visitors should be encouraged to be examined in the Emergency Room in order to determine the extent of injury and any treatment necessary.

QUALITY ASSURANCE INFORMATION FLOWCHART



CONSCIOUS SEDATION WORKGROUP



CONSCIOUS SEDATION TEAM

- ◆ CDR K. KERRIGAN
- ◆ CDR T. ALLINGHAM
- ◆ CDR P. NETZER
- ◆ LCDR E. ZINTZ
- ◆ LCDR E. BRACKEN
- ◆ LCDR K. MILLER

CONSCIOUS SEDATION WORKGROUP

UNDERSTANDING EXISTING CONDITIONS

Initially, an opportunity for improvement was presented by the Radiology Department to the Pediatric and Anesthesia Departments. There appeared to be a different standard of care for children requiring diagnostic procedures and conscious sedation than for adults. Children below the age of six or seven require the administration of an oral sedative in order to perform certain diagnostic procedures. The use of a sedative (depending on the dosage) can alter the child's breathing patterns and ability to maintain a consistent oxygen level. Normally, patients receiving sedation have their blood pressure, oxygen saturation, EKG, and mental status monitored throughout the process. Performing the procedure in the clinic promotes consistency of care, the use of monitors, and thorough documentation. Usually the physician is in the room performing the procedure or within close proximity. Pediatric procedures are usually performed by technicians and require the child to leave the clinic.

Previously, an infant or child requiring a diagnostic procedure (MRI, urodynamic study, EEG, CAT scan, or BAER) would present to the Pediatric Clinic for sedation. The clinic may or may not have known of the procedure. This caused disorder in an already busy clinic day. There was also a high sedation failure rate because the family received no preprocedural teaching concerning sleep deprivation, NPO status, and procedure expectations.

The child would be assessed, the sedation given, and the child transported to the procedure area (See Current Process Flow Chart). The child would be monitored visually by the radiology technician but no documentation was maintained of pre, intra, or post procedural vital signs.

Customer requirements prior to the start of the project included:

- Safe care
- Appropriate documentation of the procedure
- Establishment of a relationship with the health care workers providing care
- Health teaching appropriate to the procedure and the patient's/family's educational level
- Efficient service that meets customer needs

Organizational goals and status prior to start of project:

- Diagnostic procedures were task driven not customer oriented
- Children sedated in the least complicated manner did not consider the needs of the patient or family
- Minimal input by patient or family concerning their expectations
- Short fused scheduling eliminated or minimized patient education and nurse interaction

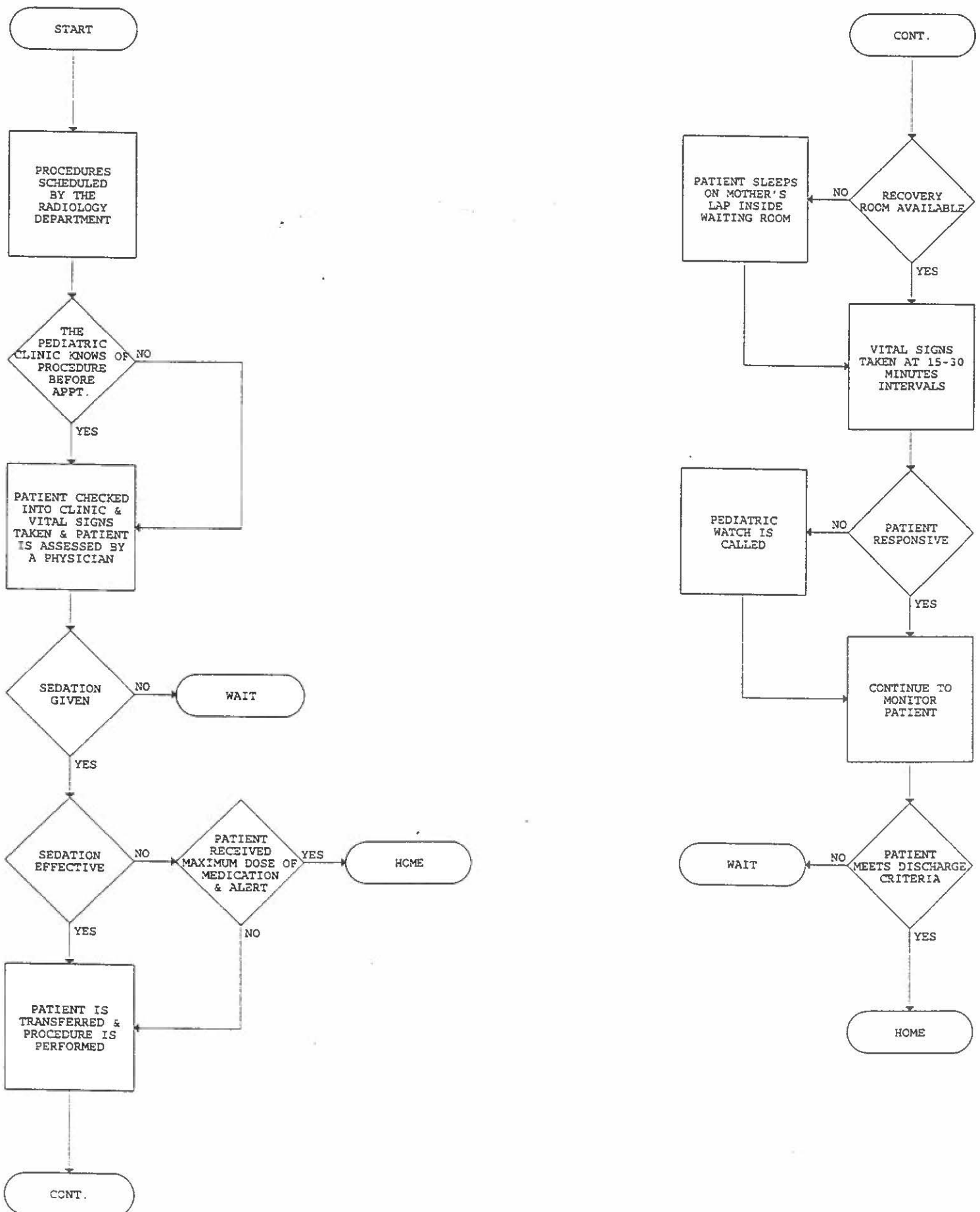
The team's opportunity statement read:

"An improvement opportunity exists in the monitoring of pediatric conscious sedation cases beginning with scheduling of the procedure and ending with the discharge of the patient from the unit. Improvement will result in better documentation of pre, intra, and post procedural monitoring."

Other Customer/Organizational goals to be achieved by project included:

- Continuity of documentation
- Patient monitoring pre, intra, and post procedure
- Coordinated interdepartmental appointment scheduling
- Centralized monitoring area

Monitoring of compliance with departmental and command guidelines for conscious sedation were performed by the Quality Improvement (QI) office. Periodic review revealed that other clinics performing conscious sedation were complying with written guidelines. The Pediatric Clinic's documentation fell short of expectations. As the process took shape, the team relied upon flowcharting of the current process, brainstorming, and cause and effect diagrams.



SELECTION OF PROJECT/PROCESS

Over approximately 18 months, there were two teams involved in the development of conscious sedation policies. The first team developed guidelines to be used throughout the command. The second worked specifically on the issue of improving pediatric conscious sedation procedures. This second team was never a formalized Process Action Team. It was more an interdepartmental Quality Circle whose opportunity was developed by Radiology Department. The department noted that there was a difference in the standard of care between adults and children. The QI officer also had performed a chart review. The purpose of the review was to determine if criteria for conscious sedation were documented as outlined in departmental policies.

While it was considered a Quality Circle, it had full support of the Executive Steering Committee. As the Opportunity Statement read, improvement would result in better documentation of pre, intra, and post procedural monitoring.

An opportunity for improvement was recognized when the chart review revealed a lack of appropriate documentation for pediatric conscious sedation patients.

Reasons for selection of this process included the consideration of costs to the family and command, quality, and the delivery of care. Procedures such as MRI, CAT Scan, EEG, urodynamic studies, and hearing tests are performed on pediatric patients throughout the community.

If the Military Treatment Facility (MTF) is unable to provide specific services, the customer is "disengaged". Disengagement is an action where services are not provided by the MTF either due to lack of appropriate equipment or medical providers. The patient must be sent to a facility outside of the military healthcare system that can provide the services. This is a very unpopular action that leads to customer and command dissatisfaction since there is a 20% customer co-payment, and an increase in CHAMPUS dollars spent. State-of-the-art equipment is owned by the command to perform these procedures. Our providers are some of the best trained physicians and technicians in the system. Limiting care was not customer oriented.

Team members represented the departments directly involved in Pediatric Conscious Sedation (Anesthesia, Pediatrics, Radiology, Nursing, and Surgery).

ANALYSIS OF PROBLEM OF PROCESS CAUSE(S)

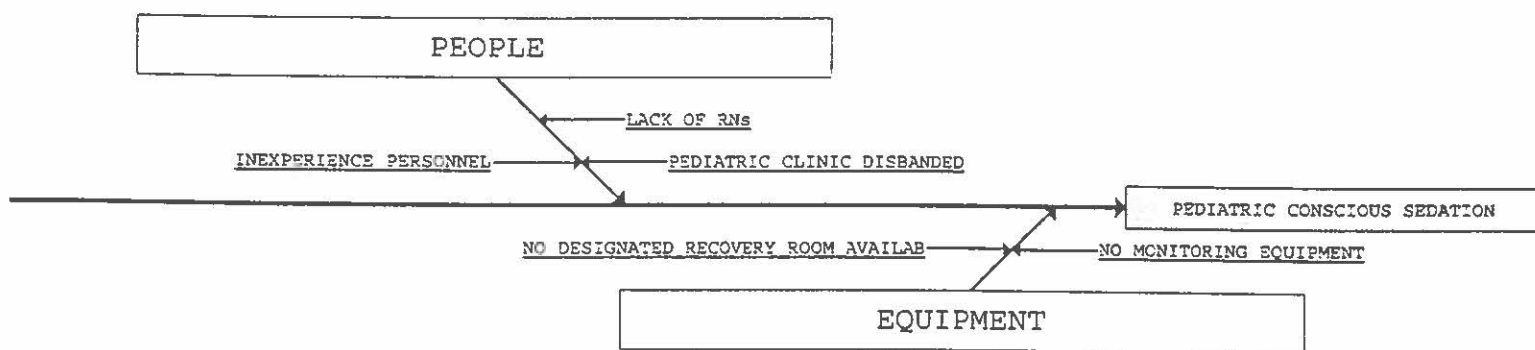
The first indication that a problem existed occurred during a periodic chart review performed by the QI office. The review examined patient charts from clinics performing conscious sedation. While the Pediatric Clinic had very specific guidelines, they were unable to comply with their own written policy for the following reasons:

- Lack of coordinated interdepartmental appointment scheduling-unexpected requirements for procedures and sedation
- No centralized patient monitoring area
- Lack of staff for monitoring assignments outside of the clinic
- Lack of continuity in documentation throughout the procedure.

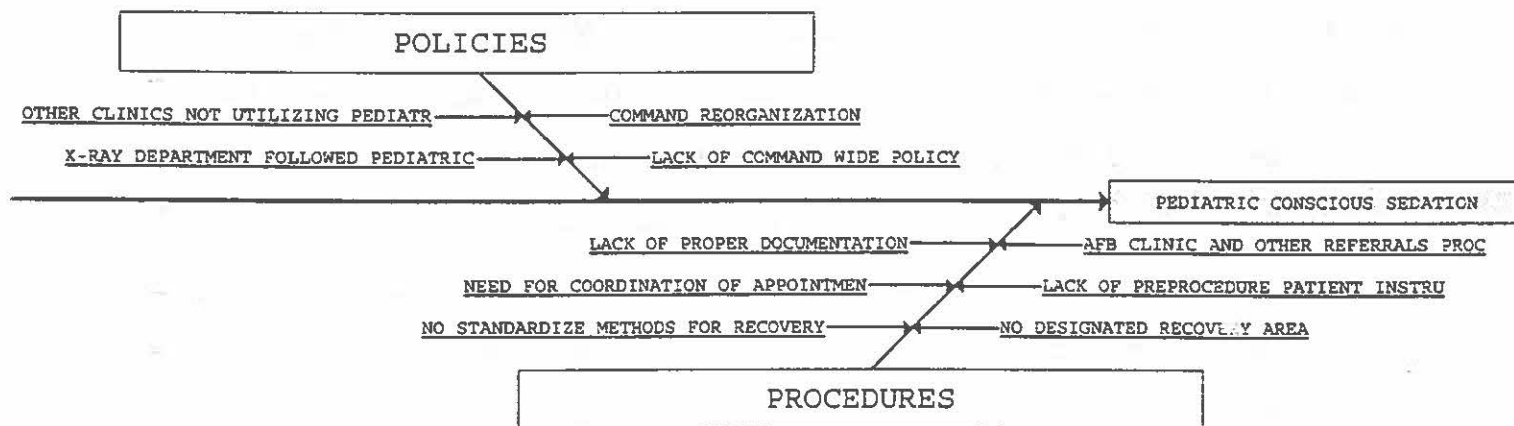
A cause and effect diagram developed later revealed the root causes of the problem were attributed to "people" and "procedures" problems (See Cause and Effect Diagram).

"People" issues were directly related to the lack of registered nurses in the Pediatric clinic. Causes of the problem related to "Procedures" were far more diversified and more complex. "Procedures" reached beyond the department and involved scheduling requirements, appropriate monitoring areas, and procedures that facilitated the process.

EXAMPLE 00 (Fishbone Diagram)



EXAMPLE 00 (Fishbone Diagram)



IMPLEMENTATION

The initial solution was to continue performing pediatric procedures in the clinic, to augment the nursing staff, to provide a room dedicated for monitoring patients before and after the procedure, and to improve documentation of patient vital signs. The team was suddenly faced with a new challenge-reorganization and the dissolution of the Pediatric Clinic. In October, 1994, the Pediatric, Family Practice, Internal Medicine, OB/GYN, and General Surgery Clinics were disbanded and the physician and support staffs assigned to primary care teams. It then became apparent that the initial solution was not viable.

The second solution considered was to use the newly developed Ambulatory Procedures Unit (APU) as a clearing house for the admission and discharge of pediatric conscious sedation patients. The purpose of the APU was to perform the invasive and noninvasive procedural functions of the clinics that were disbanded. Staffing was still an issue in the APU. Performing a pediatric procedure outside of the APU meant delaying other surgical cases until the nurse returned from the Radiology. In order to meeting staffing needs, the Department Head, Perioperative and Ambulatory Services decided to use operating room (perioperative) nurses as nurse monitors. Operating Room nurses often monitor patients receiving local anesthesia or sedation in the surgical suite and are comfortable with this independent role. However, the barrier that was not expected was the resistance of the operating room nurses to monitor cases

outside the operating room and without the security of a nearby anesthesiologist. This barrier was overcome by allowing the nurses to meet with a pediatric anesthesiologist, pediatrician, and general surgeon outlining the side effects of the sedation method used (chloral hydrate), defining monitoring devices available, and defining their role in the process.

Training was included as part of the process. Perioperative nurses were sent to a teleconference concerning conscious sedation. The clinical instructor for the Main Operating Room also developed a self-paced educational tool on the monitoring of patients receiving local anesthesia or conscious sedation. The program of instruction included cardiac arrhythmia identification, Association of Operating Room Nurses standards, and drug reactions. This program was reviewed and approved by the Departments of Anesthesia and Nursing Education.

Documentation had been one of the initial problems identified with the program. A new nursing note was developed for all APU cases. A different type of documentation, it also required training (See Nursing Note).

Patient families were also included in the training. Previously, there was a relatively high failure rate for sedated children. The failure rate was due to too much sleep the night before, a hurried atmosphere, and poor family teaching. The parents are educated about pre-procedure requirements (sleep deprivation and no food after midnight), what to expect during the procedure, and post-procedural activity. Use of the APU

I. ASSESSMENT:

Diagnosis:

Planned procedure:

Conscious Sedation: agent _____ route _____ dose _____ time _____ IV site _____ cath size _____ fluid _____ rate [] NA

NURSING ASSESSMENT: height _____ weight _____ age _____ sex _____ pregnant [] Na [] yes [] [] no Temp: _____ Pulse: _____ BP: _____ / _____ S.O₂ _____
RESPIRATORY **CIRCULATORY** **CENTRAL NERVOUS SYSTEM** **OTHER SYSTEMS** **ASA Class**
 tobacco heart disease seizure liver (select one)
 uri sob cva etoh [I]
 asthma htn neuro dz renal [II]
 th anemia muscle glaucoma [III]
 copd ekg loc endocrine [IV]
 (if ASA Class III or IV, MD notified: _____)

Pertinent Medical and Surgical History:

Present drug therapy, treatment, or limitations:

Tests/studies ordered: [] NA [] CBC [] SMA6 [] Hcg [] ua [] Ekg [] Other: _____ Allergies to Foods/Drugs: [] no [] yes _____

Comments:

Patient or guardian relates an understanding / comprehension of [] planned procedure(s): _____: [] prep responsibilities;
 [] PO status, [] monitoring/equipment; [] positioning; [] APD routine; [] discharge instructions; [] accompanied by adult driver

Pre-procedural Interview Conducted By:

Date:

Time:

Location:

II. PERI-PROCEDURE STANDARDS OF CARE

#	Patient Problem	Expected Outcome	Nursing Interventions
1	Anxiety related to surgical procedure and separation from relatives	A. Verbalizes specific concerns B. Exhibits relaxed body posture	1. Encourage patient to verbalize anxieties 2. Patient greeted at each encounter 3. Discussion of environment factors / routine
2	Potential loss of privacy	A. Privacy is maintained	1. Maintain confidentiality 2. Keep patient covered except as necessary; sedation / monitoring / procedure 3. Allow only appropriate staff attendance
3	Potential for unplanned impairment of skin integrity	A. No pressure areas or skin breakdown	1. Pad all potential pressure areas 2. Correctly place all equipment 3. Maintain proper body alignment, using positioning aids as appropriate
4	Potential loss of body core heat	A. Conservation of body core heat	1. Apply pre-warmed sheet in room 2. Keep patient covered except as necessary; sedation / monitoring / procedure 3. Use appropriate warming devices
5	Potential loss of homeostasis due to preparation/sedation/procedure	A. Vital signs will remain stable	1. Check lab values 2. Fluid replacement available 3. Assist in monitoring blood / fluid loss 4. Monitor vital signs as appropriate

Care Plan by:

Date:

Time:

Location:

III. ADMISSION AND INTRA-PROCEDURAL NURSING NOTE: Date: _____ Time: _____

IDENTIFY: [] Band [] Verbal [] Other: _____
 Adult driver/parent/legal guardian location status:
 TRANSFER from: _____ to _____
 via: [] Ambulatory [] Wheelchair
 [] Gurney [] Crib [] Other: _____
 MENTAL STATUS:
 [] Arousable [] Alert [] Calm
 [] Apprehensive [] Sedated
 CONFIRM PREP: [] yes [] no

REMOVED: [] Valuables / Jewelry
 [] Dentures: () Upper () Lower
 [] Partial :
 [] Hearing Aid(s) [] Glasses
 Disposition:
 IV STARTED: [] NA
 Size: _____ Fluid Type:
 Site: _____ Rate:
 POSITIONING: (select one)
 [] Supine [] Prone [] Lateral (R)(L)
 [] Lithotomy [] Jack-knife

SAFETY RESTRAINTS:
 [] Belt: (R)(L) leg () hips () thighs
 [] Arms: () R () L tucked @ side
 () R () L secured armboards
 [] Siderails up [] NA
 TESTS RESULTS (If Applicable):
 SMA6 [] WNL UA [] WNL
 CBC [] WNL HCG [] [] []
 RN Signature: _____

ADDRESSOGRAPH

Conscious Sedation NATHOSP CHASN (Rev.11/94)

allowed the nursing staff to spend more time with the patients pre-procedure. The family is included in every phase of the child's care while in the APU.

APU and the department of Pediatrics developed a departmental policy on conscious sedation. The physicians were heavily involved in defining the details concerning admissions, history/physical, informed consent, and pre-sedation teaching. Nursing documentation was reviewed and revised. The new nursing note included pre-procedural assessment, documentation of intra-procedural monitoring and events, and post procedural sequelae. They also developed patient family teaching handouts. This outlined what the family needed to do the night before and the morning of the procedure. A post sedation parent education sheet was also developed identifying the signs and symptoms of adverse effects and points of contact if any questions should arise.

Long term implications were considered. There is nothing more disconcerting and dissatisfying to a customer than to be faced with multiple changes and the appearance of indecision. The team felt that having the process centered in APU was the right decision. Other minor changes could be implemented to improve the process with little customer inconvenience.

The success of the team was shared through display of the team's story board, e-mail, department head meetings, staff meetings, and APU's grand opening. The team's efforts were

presented as part of the command's recent Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey.

The pediatricians developed a concurrent chart review tool identifying seven interdisciplinary criteria for chart review. 100% of the pediatric conscious sedation charts are reviewed every month using this tool.

The chairman of the Invasive Procedures and Transfusion Committee (IPTC) decided that APU was the principal place for providing the service. He presented the decision to the Department Head, Perioperative and Ambulatory Services who in turn met with the Assistant Department Head, APU in mapping out the implementation process.

RESULTS

The team saw improvement in the process almost immediately (See Improved Flow Chart). Staffing issues no longer plagued the process. Policies and procedures were written and implemented without delay. Improvements included:

- Utilization of APU and its Recovery Room
- Development of standardized policies
- Utilization of perioperative RNs as monitors,
- Centralization of scheduling procedures (all parents come through APU either by phone or in person to schedule pediatric patients requiring conscious sedation)
- Revision of APU nursing note

Documentation was certainly improved with implementation the second solution. This was verified in a new record review initiated by the QI office in January, 1995. While APU has no "before" figures, it has maintained records of sedation failures. Since October, 1994, APU was responsible for sedating 65 children. Out this number, only two failed sedation and had to consult with Anesthesia for a different level of care.

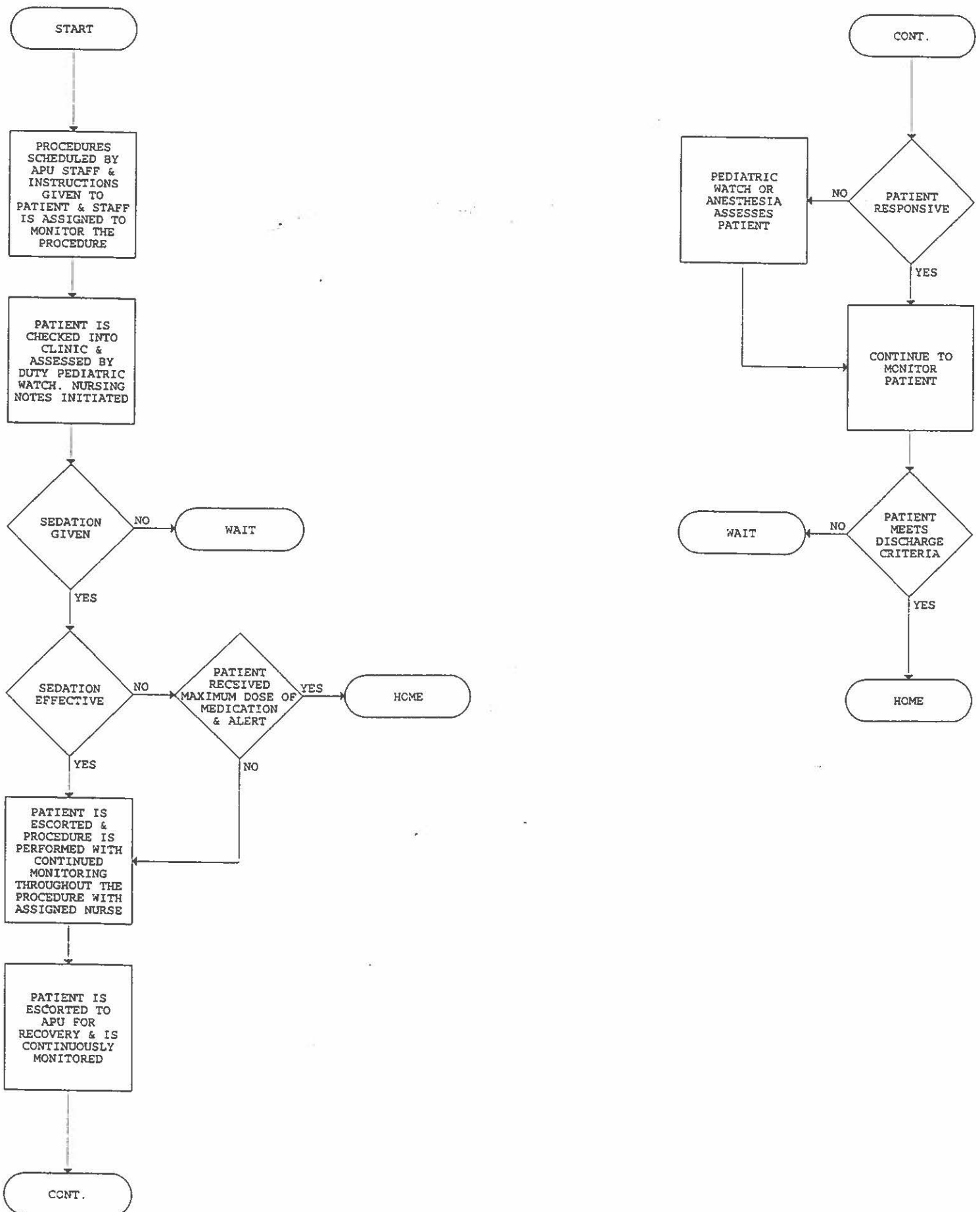
5. c. All expected results were achieved.

5. d. Unexpected results abound! The parents seem very satisfied. This is a very scary time in their lives since their child is facing a major diagnostic workup for a devastating and/or long term problem. The nurse/family relationship plays a vital role in reassuring, educating, and counseling the family

during this very trying time.

The sedation failure rate is 3%. While the team has no previous number to compare this to, the Radiology Department feels that there has been a significant decline in sedation failures.

The operating room nurses have become very comfortable in their new role. Many ask for daily assignment to the conscious sedation room. They love interacting with the families and children and find the work truly challenging.



STANDARDIZATION AND PREVENTION

Team members were process owners, therefore the team possessed profound knowledge of the issues involved. Many came to the command with at least basic TQL training and knowledge. We were the process owners, therefore, the team had profound knowledge of the problems. "Just in time training" was provided to facilitate and clarify issues concerning the project.

The standard operating procedures were changed to comply with the American Academy of Pediatrics standards of care for pediatric conscious sedation. Monitoring is consistent for every patient. No deviation is acceptable.

Documentation included the development and implementation of standardized policies and procedures.

Control techniques were not necessary since there was need for validity checks.

REFLECTIONS AND PLANS FOR CONTINUOUS IMPROVEMENT

The Department of Radiology feels comfortable with performing these procedures outside of the clinic environment.

Future benefits include the expansion of APU capabilities and the use of sedation techniques for other non-pediatric patients outside of the clinic environment.

We are providing a safe environment for the patient and their families. Standards of care and services provided are consistent throughout the facility.

The team story board has been on display within hospital and in the APU. Use of team approach in recent JCAHO survey. APU's storyboard was recently sent to the Navy Directors of Nursing Service Conference in Washington, D.C.

The team plans to meet periodically to discuss issues dealing with documentation, procedures, and other refinements. As issues arise, they are confronted, challenged, and overcome.

It would have been interesting to see how our clients saw the process before the solution was implemented. Their input would have been invaluable and might have taken us in a different direction and spurred activity sooner in the process.

We should have included any staff member that would have definitely would have an impact on the outcome (i.e. perioperative nurses, audiologists, MRI technicians). Including

perioperative nurses sooner in the process might have eliminated the barrier that we encountered just before implementation of the final solution.

Many of the original members left the command before the final solution was implemented. Many of them felt frustrated by a sense of inactivity. It is safe to say, that the second team "stood on the shoulders" of their predecessors. The realization of the team's goal would not have been possible without the strong foundation that the initial members laid.

2 Feb 1996

From: Department Head, Perioperative and Ambulatory Services
To: Director Clinical Services

Subj: SURGICAL SERVICES STATISTICS CY95

Encl: (1) Annual Statistics Operating Room 1989-1995
(2) Surgical Services 1995 Monthly Statistics
(3) Total Number of Cancellation CY95
(4) Minor Surgical Procedures CY94 vs CY95
(5) Endoscopies Procedures CY94 vs CY95
(6) Non-Invasive Procedures CY95

1. Enclosure (1) indicates a decrease* of 26.8% in the total number of surgeries performed between 1994 and 1995.

2. The data for the individual surgical services were retrieved using the monthly Operating Room Statistics. The numbers represent scheduled, emergency, and add-on surgeries. Percentages were calculated comparing CY95 to CY94 (see enclosure (2)). The results are as follows:

General Surgery	-24.95%
Gynecology	-37.79%
Ophthalmology	-33.05%
Oral Surgery	-32.43%
Otolaryngology	-23.84%
Orthopedic Surgery	-13.41%
Urology	-15.31%

Even surgical services with a positive trend in CY94 (GU and Eye) experienced a decline in the number of surgical procedures for CY95. A steady decline was seen in all surgical services throughout the year with the lowest number of procedures performed in September, October, and November. By September, five surgical services lost a total of 10 providers. By November, three new providers were onboard for Ophthalmology, Orthopedics, and General Surgery. The low number of surgical procedures performed in November represented new providers building their caseloads and the impact of the civilian furlough.

3. Pediatric Conscious Sedation had no CY94 statistics for comparison. Sixty-four pediatric sedation cases were performed with a cancellation rate of 17% (11). The department will track cancellations and failure rates for CY96.

4. The surgical cancellation rate (see enclosure (3)) for CY95 represented 277 patients (11.4%). Statistics are maintained in the department outlining each services cancellation rate for the year.

5. APU has now been in existence for 17 months. CY95 statistics were compared with CY94 statistics from the General Surgery

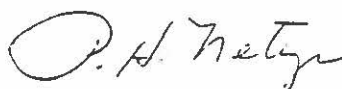
Clinic (see enclosure (4) and (5)). The results are as follows:

Minor Procedures (666)	-8.66%
Endoscopies (1064)	+5.14%

Starting in February, APU will perform procedures for Urology and Oral Surgery. Eventually, Dermatology will perform tumescent liposuction in APU once Dr. Mitchell is credentialed.

6. There were no statistics for comparison for the noninvasive side of APU. This division performed 3830 procedures in CY95 (see enclosure (6)).

7. This data does not represent acuity or total length of surgery.

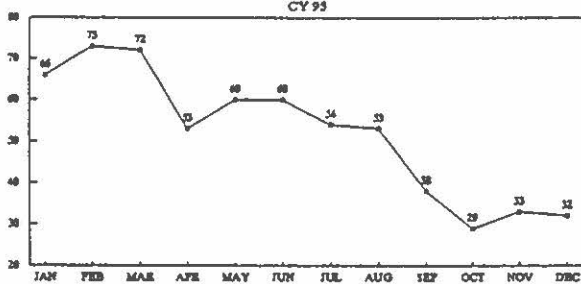


P. H. NETZER

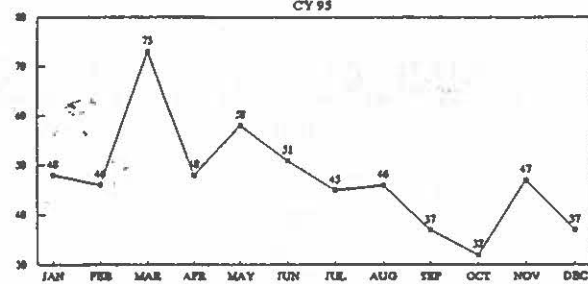
SURGICAL SERVICES 1995 MONTHLY STATISTICS

MONTH	GENERAL	ORTHO	GU	GYN	ENT	EYE	DENTAL	SEDATION
JAN	66	48	14	41	29	28	1	6
FEB	73	46	19	31	33	11	4	9
MAR	72	73	32	40	54	14	5	6
APR	53	48	22	24	37	13	3	7
MAY	60	58	22	28	53	16	6	7
JUN	60	51	22	33	37	6	3	6
JUL	54	45	21	27	40	13	7	3
AUG	53	46	19	32	34	17	8	3
SEP	38	37	22	22	25	9	2	4
OCT	29	32	21	30	28	13	3	6
NOV	33	47	19	16	13	8	3	5
DEC	32	37	24	20	26	10	5	2
TOTAL	623	568	257	344	409	158	50	64

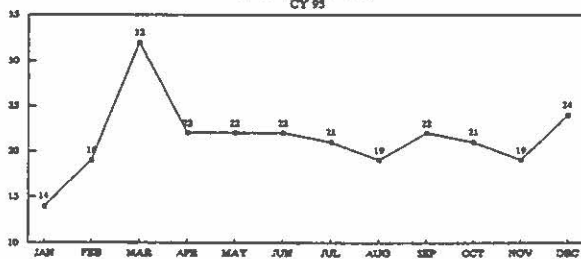
GENERAL SURGERY



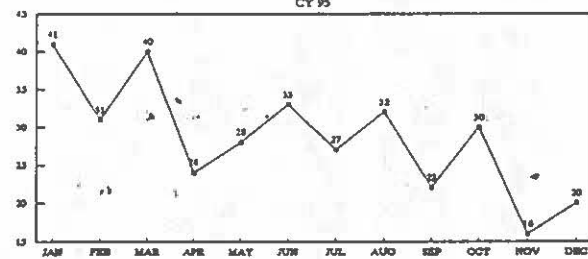
ORTHOPEDIC SURGERY



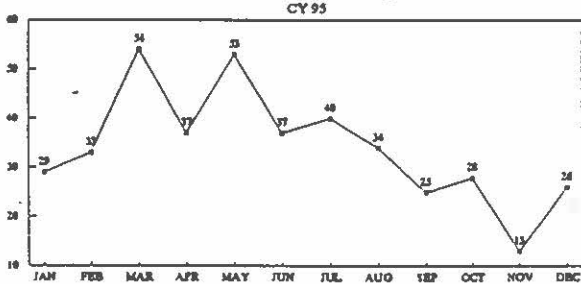
UROLOGY



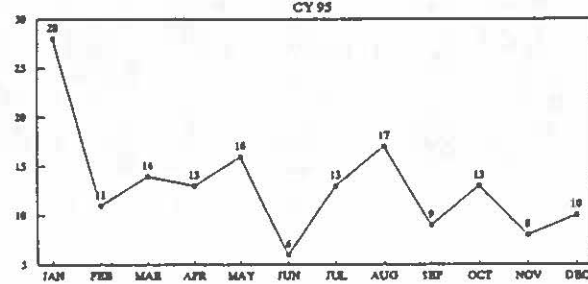
GYNECOLOGY



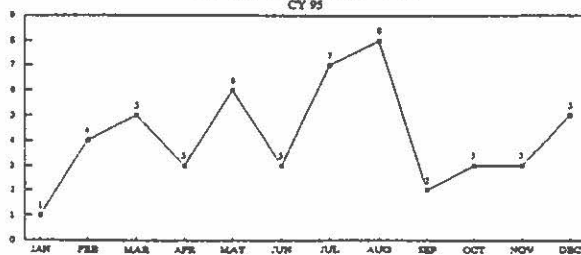
OTOLARYNGOLOGY



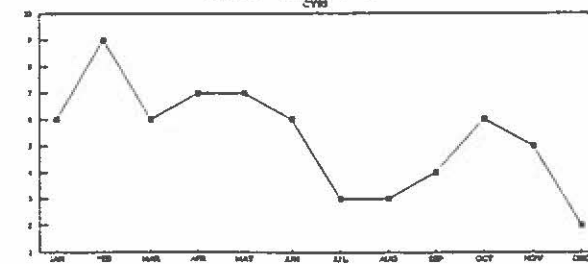
OPHTHALMOLOGY



ORAL SURGERY



PEDS CONSCIOUS SEDATION



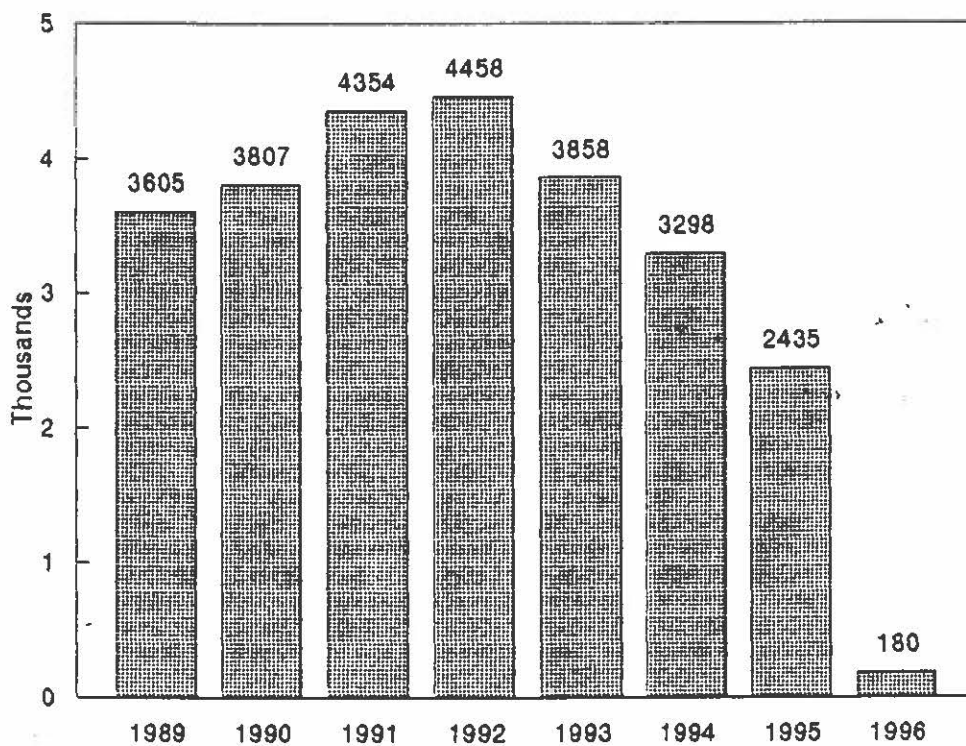
ANNUAL STATISTICS OPERATING ROOM

1989-1996

YEAR	TOTAL CASES
1989	3605
1990	3807
1991	4354
1992	4458
1993	3858
1994	3298
1995	2435
1996	180
	25995

ANNUAL STATISTICS

1989-1996



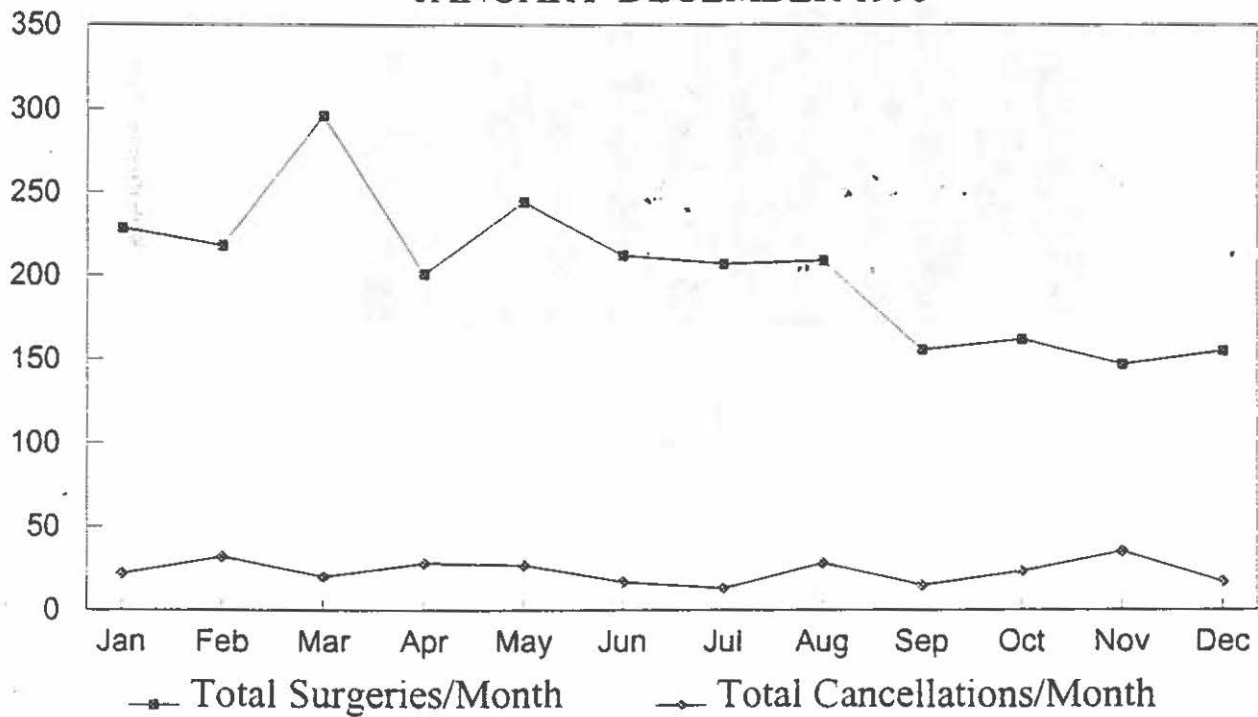
***SURGERIES DECREASED BY 14.52% FROM 1993 TO 1994

***SURGERIES DECREASED BY 26.8% FROM 1994 TO 1995

**TOTAL NUMBER OF CANCELATIONS
CY 1995**

Month	Total Cases	Total Cancelled	% Cancelled
Jan	228	22	9.6%
Feb	218	32	14.7%
Mar	296	20	6.8%
Apr	201	28	13.9%
May	244	27	11.1%
Jun	212	17	8.0%
Jul	207	13	6.3%
Aug	209	28	13.4%
Sep	156	15	9.6%
Oct	162	23	14.2%
Nov	147	35	23.8%
Dec	155	17	11.0%
Total	2435	277	11.4%

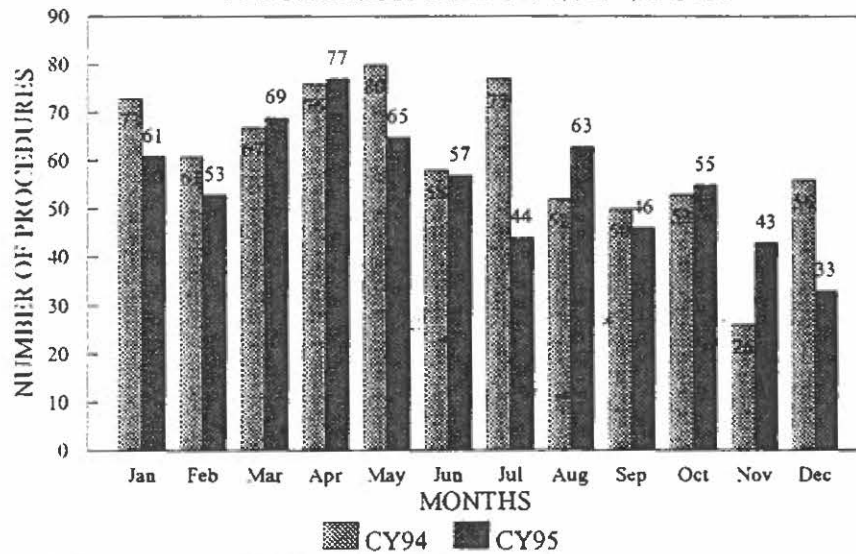
**CANCELLATIONS PER MONTH
JANUARY-DECEMBER 1995**



**COMPARISON GENERAL SURGERY CLINIC VS APU STATISTICS
MINOR SURGICAL PROCEDURES
CY 1994 VS CY 1995**

MONTH	CY94 PROCEDURES BY MONTH	CY95 PROCEDURES BY MONTH
Jan	73	61
Feb	61	53
Mar	67	69
Apr	76	77
May	80	65
Jun	58	57
Jul	77	44
Aug	52	63
Sep	50	46
Oct	53	55
Nov	26	43
Dec	56	33
TOTAL	729	666

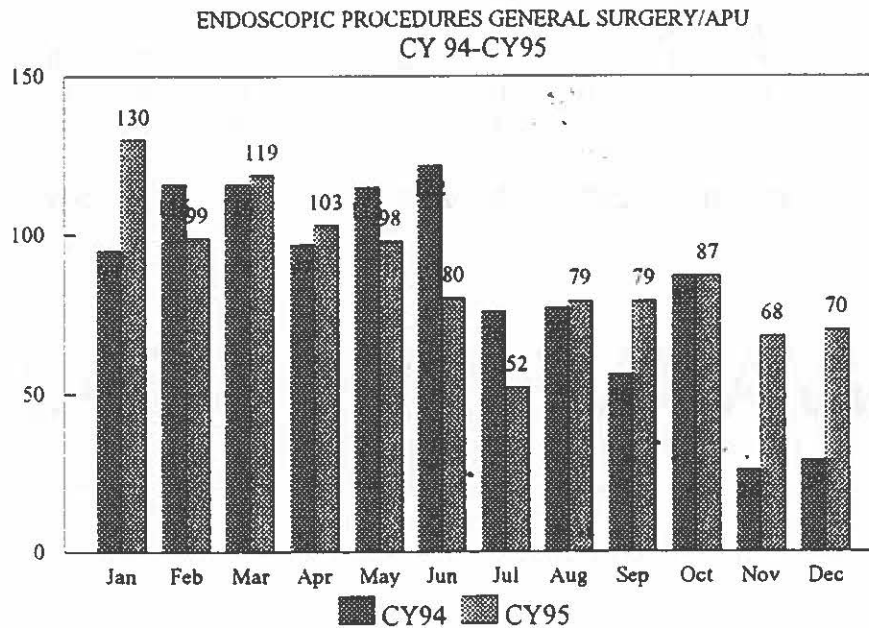
**GENERAL SURGERY CLINIC/APU STATISTICS
MINOR PROCEDURES CY92, CY94, & CY95**



SEPT 94 GENERAL SURGERY CLINIC DISBANDED; PROCEDURES PERFORMED IN APU IN OCT 94

**COMPARISON GENERAL SURGERY CLINIC VS APU STATISTICS
ENDOSCOPIES PROCEDURES
CY 1994 VS CY 1995**

MONTH	CY94 ENDOSCOPIES BY MONTH	CY95 ENDOSCOPIES BY MONTH
Jan	95	130
Feb	116	99
Mar	116	119
Apr	97	103
May	115	98
Jun	122	80
Jul	76	52
Aug	77	79
Sep	56	79
Oct	87	87
Nov	26	68
Dec	29	70
TOTAL	1012	1064



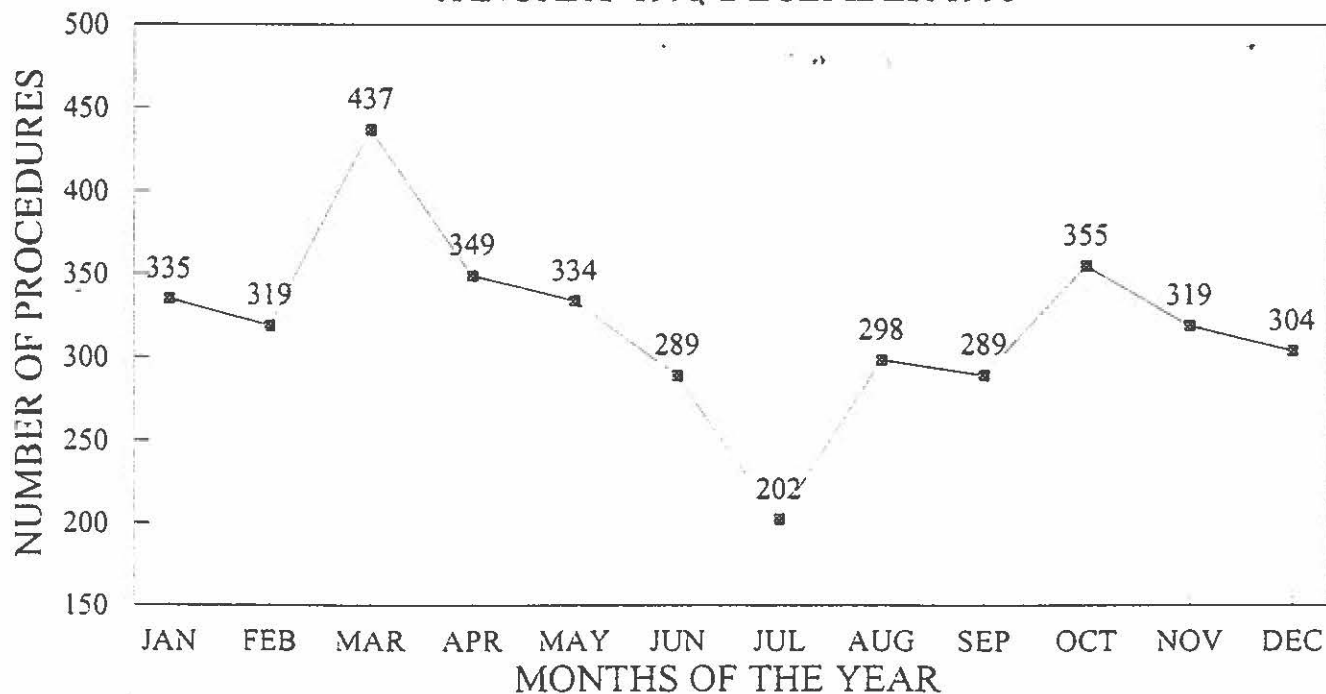
ENDOSCOPIES PERFORMED IN APU AFTER SEPTEMBER, 1994
 JAN 95 NUMBER OF PROCEDURES COUNTED VICE NUMBER OF PATIENTS

AMBULATORY PROCEDURES UNIT NON-INVASIVE PROCEDURES JANUARY 1995-DECEMBER 1995

Studies	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Consults	38	36	37	37	42	36	21	41	31	39	36	30	424
F/U	26	12	35	29	24	23	11	14	16	16	12	19	237
W/I	4	27	6	1	1	3	0	3	1	19	27	19	111
EKG	107	90	139	81	93	83	65	103	92	100	90	94	1137
EST	34	60	65	54	34	40	20	39	46	62	60	43	557
Echo	48	39	56	45	43	40	23	31	37	45	39	34	480
PFT	42	19	49	41	44	24	26	33	30	22	19	17	366
Holter	15	13	24	31	15	14	11	10	12	19	13	13	190
Dapt	17	11	20	20	21	12	13	12	12	10	11	14	173
Telco	2	0	2	0	0	0	0	0	0	1	0	0	5
EEG	2	6	4	7	10	7	5	4	9	5	6	6	71
NST	0	0	0	0	0	0	0	0	0	10	0	11	21
Poly	0	6	0	3	7	7	7	8	3	7	6	4	58
TOTAL	335	319	437	349	334	289	202	298	289	355	319	304	3830

NONINVASIVE PROCEDURE

JANUARY 1995-DECEMBER 1995



—■— TOTAL PROCEDURES/MONTH

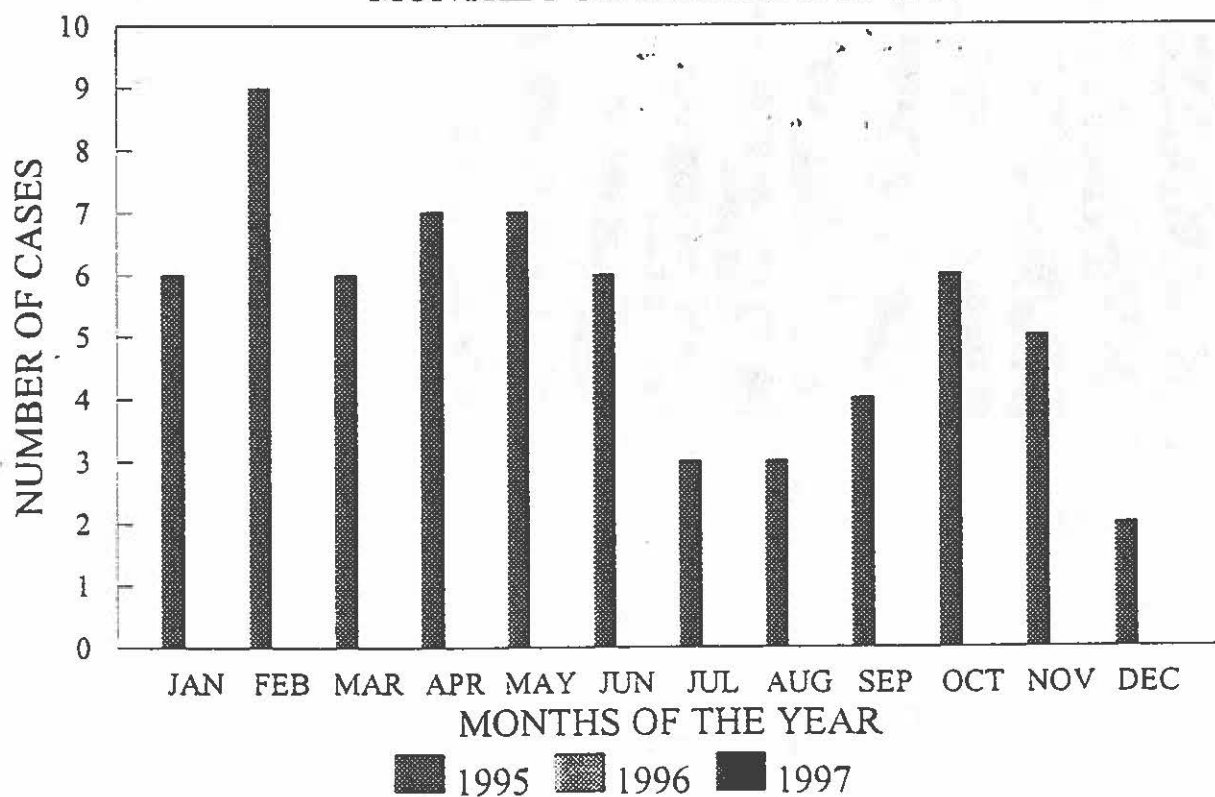
November 95-5 days of furlough

CONSCIOUS SEDATION STATISTICS 1995

MONTH	1995	1996	1997
JAN	6	0	0
FEB	9	0	0
MAR	6	0	0
APR	7	0	0
MAY	7	0	0
JUN	6	0	0
JUL	3	0	0
AUG	3	0	0
SEP	4	0	0
OCT	6	0	0
NOV	5	0	0
DEC	2	0	0
TOTAL	64	0	0

CONSCIOUS SEDATION

MONTHLY STATISTICS 1995-1997

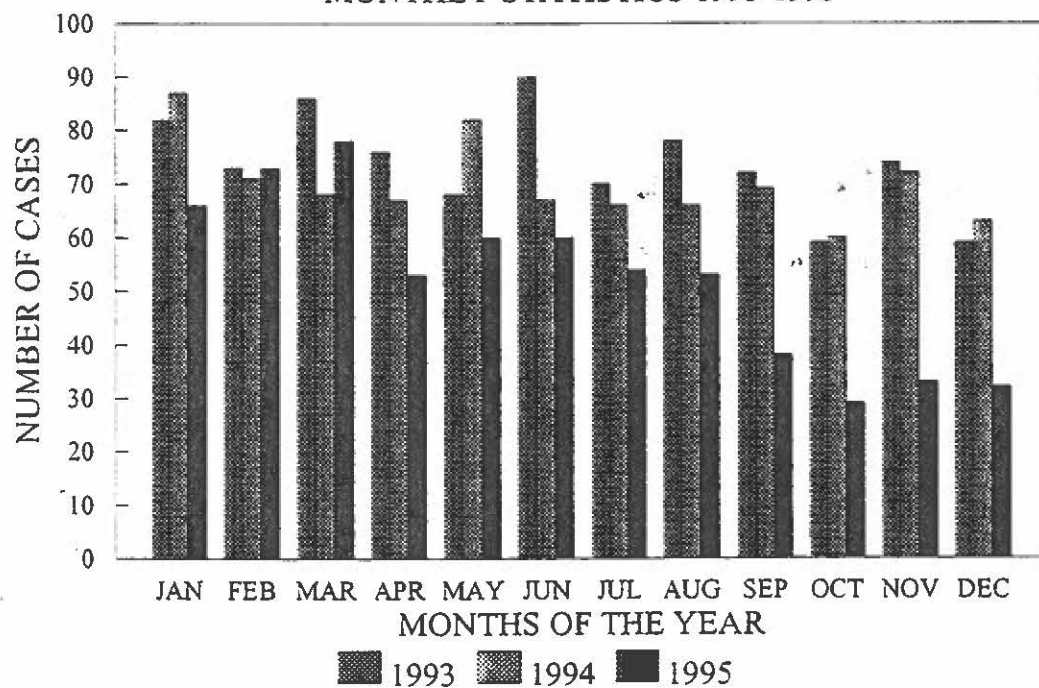


GENERAL SURGERY STATISTICS 1993-1995

MONTH	1993	1994	1995
JAN	82	87	66
FEB	73	71	73
MAR	86	68	78
APR	76	67	53
MAY	68	82	60
JUN	90	67	60
JUL	70	66	54
AUG	78	66	53
SEP	72	69	38
OCT	59	60	29
NOV	74	72	33
DEC	59	63	32
TOTAL	887	838	629

GENERAL SURGERY

MONTHLY STATISTICS 1993-1995



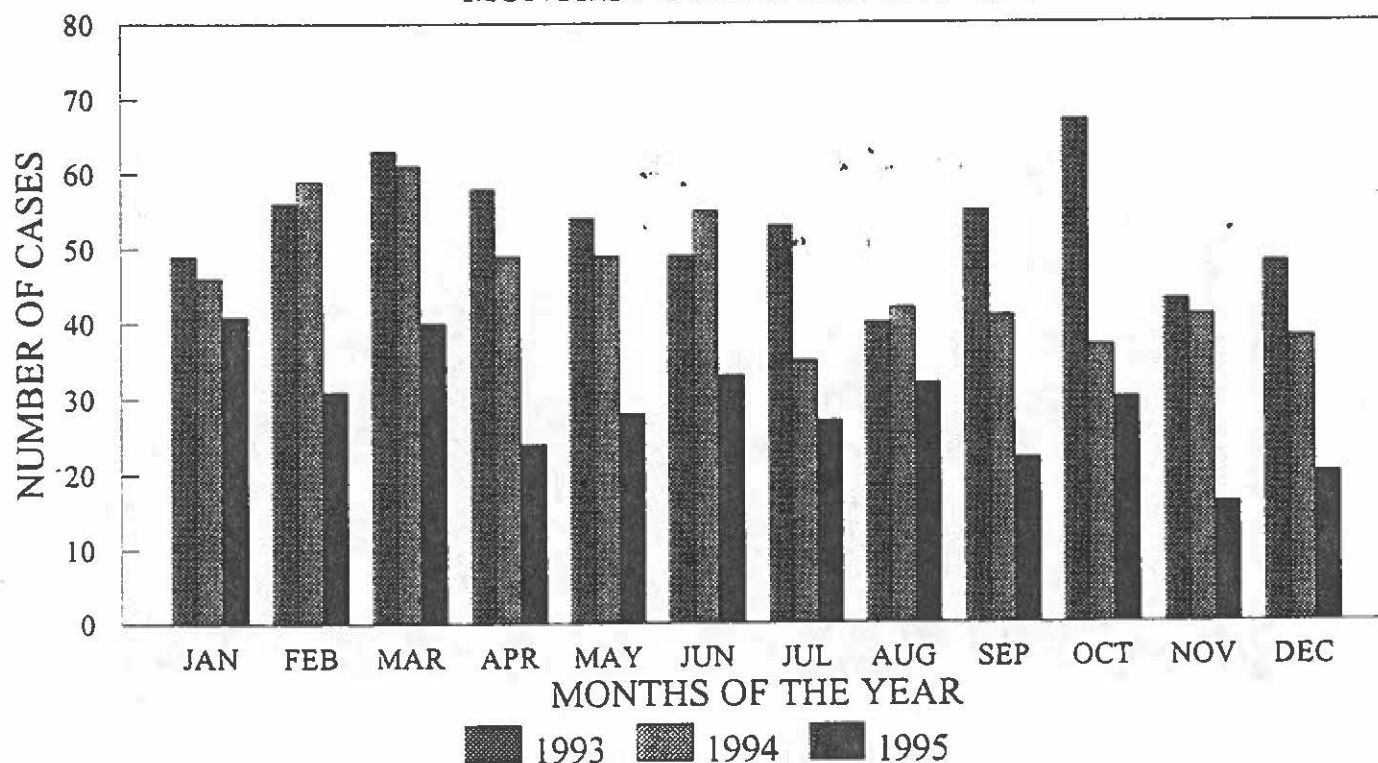
****SURGERIES DECREASED BY 5.52% FROM 1993 TO 1994

****SURGERIES DECREASED BY 24.95% FROM 1994 TO 1995

GYNECOLOGY STATISTICS 1993-1995

MONTH	1993	1994	1995
JAN	49	46	41
FEB	56	59	31
MAR	63	61	40
APR	58	49	24
MAY	54	49	28
JUN	49	55	33
JUL	53	35	27
AUG	40	42	32
SEP	55	41	22
OCT	67	37	30
NOV	43	41	16
DEC	48	38	20
TOTAL	635	553	344

GYNECOLOGY MONTHLY STATISTICS 1993-1995



****SURGERIES DECREASED BY 12.9% FROM 1993 TO 1994

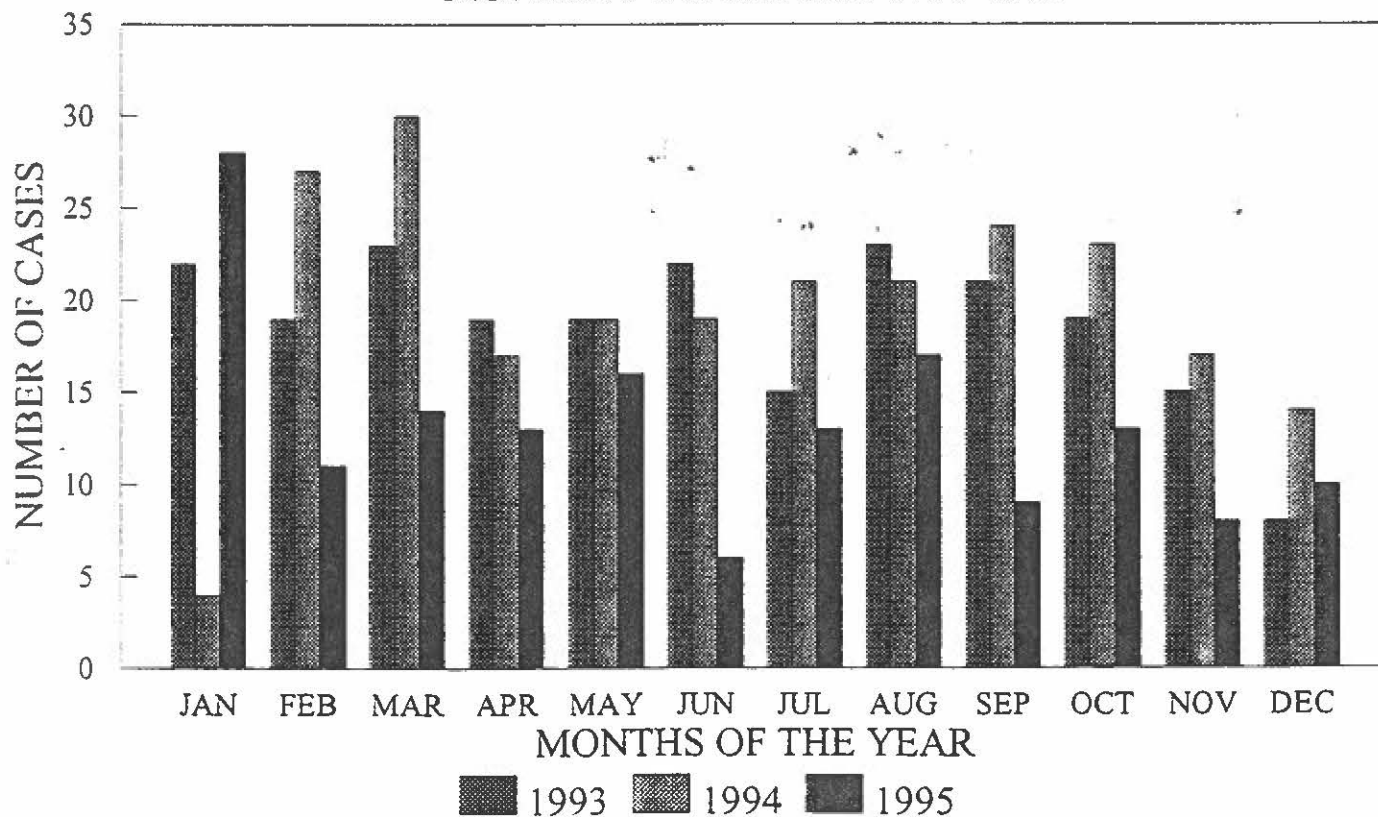
****SURGERIES DECREASED BY 37.79% FROM 1994 TO 1995

OPHTHALMOLOGY STATISTICS 1993-1995

MONTH	1993	1994	1995
JAN	22	4	28
FEB	19	27	11
MAR	23	30	14
APR	19	17	13
MAY	19	19	16
JUN	22	19	6
JUL	15	21	13
AUG	23	21	17
SEP	21	24	9
OCT	19	23	13
NOV	15	17	8
DEC	8	14	10
TOTAL	225	236	158

OPHTHALMOLOGY

MONTHLY STATISTICS 1993-1995



****SURGERIES INCREASED 5% FROM 1993 TO 1994

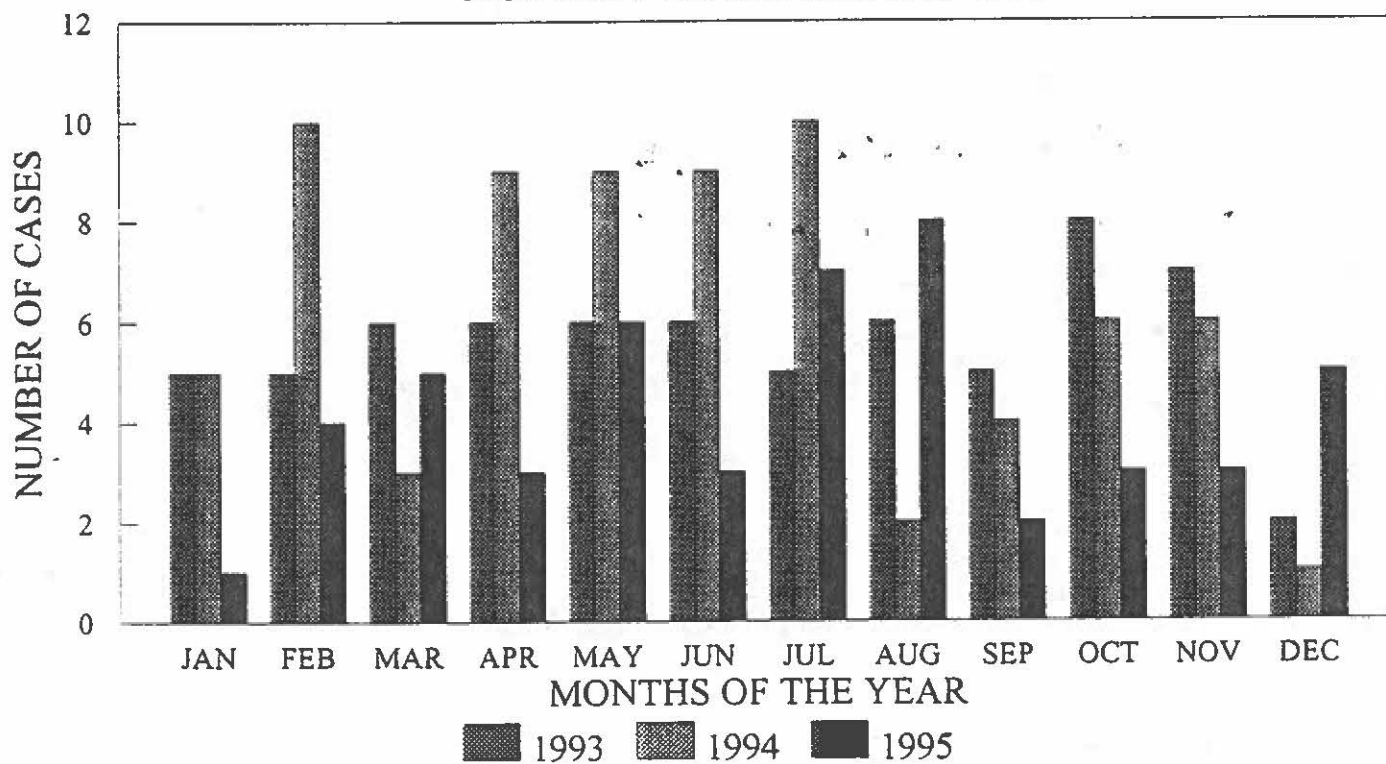
****SURGERIES DECREASED 33.05% FROM 1994 TO 1995

ORAL SURGERY STATISTICS 1993-1995

MONTH	1993	1994	1995
JAN	5	5	1
FEB	5	10	4
MAR	6	3	5
APR	6	9	3
MAY	6	9	6
JUN	6	9	3
JUL	5	10	7
AUG	6	2	8
SEP	5	4	2
OCT	8	6	3
NOV	7	6	3
DEC	2	1	5
TOTAL	67	74	50

ORAL SURGERY

MONTHLY STATISTICS 1993-1995



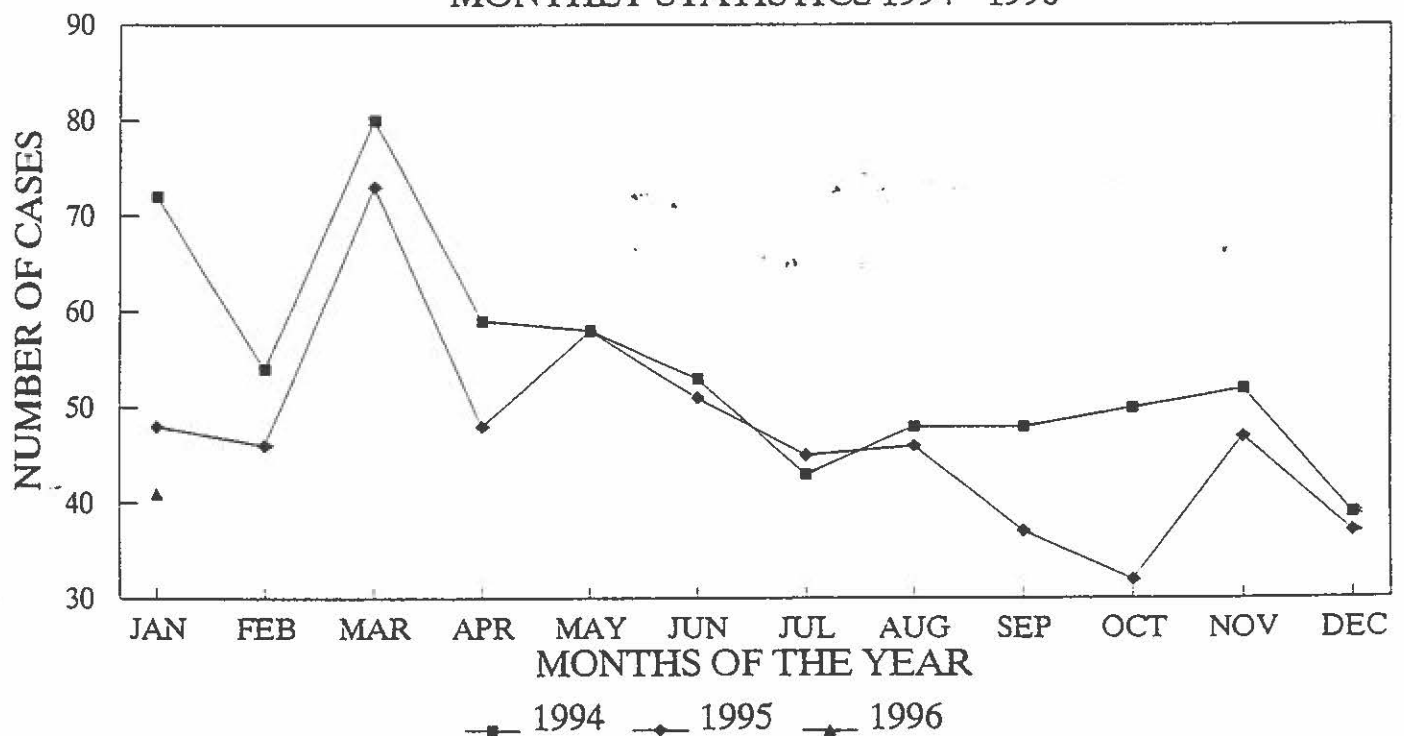
****SURGERIES INCREASED BY 10.45% FROM 1993 TO 1994

****SURGERIES DECREASED BY 32.43% FROM 1994 TO 1995

ORTHOPEDIC SURGERY STATISTICS 1994-1996

MONTH	1994	1995	1996
JAN	72	48	41
FEB	54	46	
MAR	80	73	
APR	59	48	
MAY	58	58	
JUN	53	51	
JUL	43	45	
AUG	48	46	
SEP	48	37	
OCT	50	32	
NOV	52	47	
DEC	39	37	
TOTAL	656	568	41

ORTHOPEDIC SURGERY MONTHLY STATISTICS 1994-1996



****SURGERIES DECREASED BY 20.58% FROM 1993 TO 1994

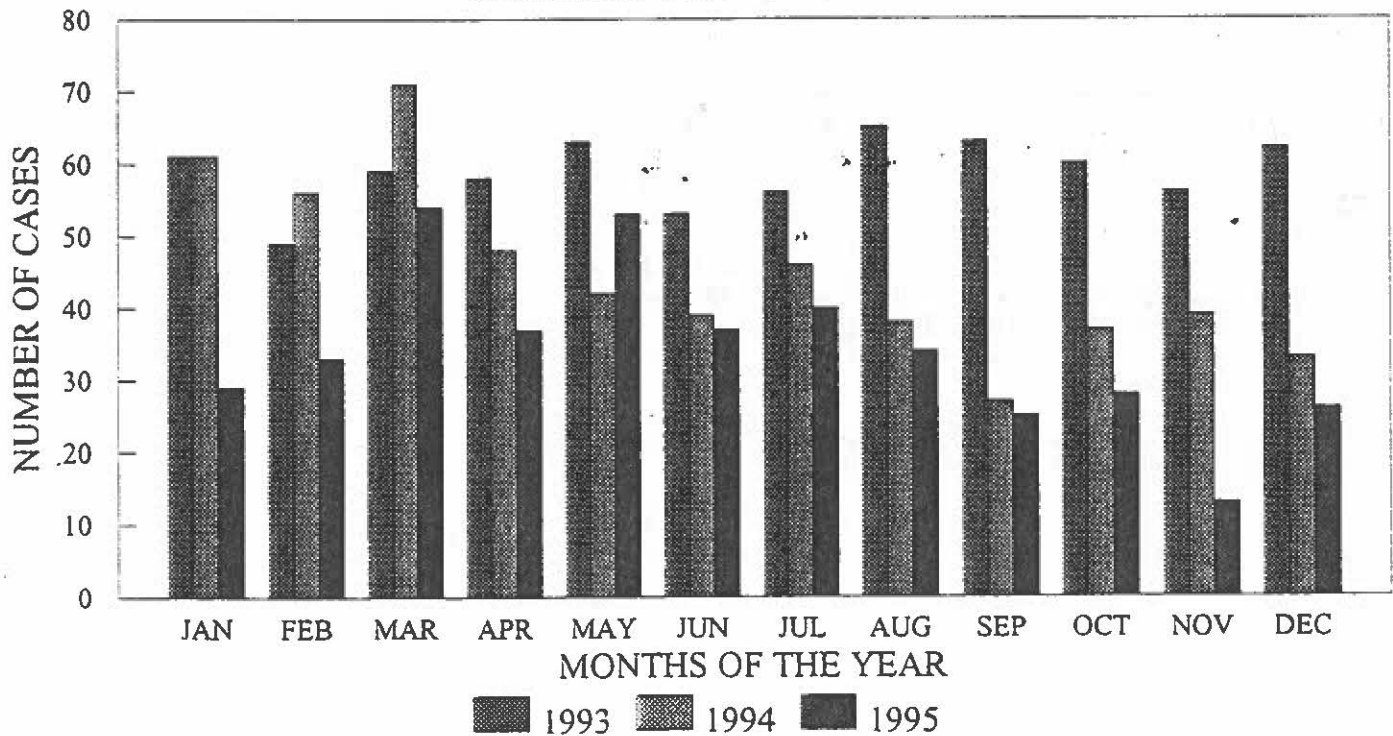
****SURGERIES DECREASED BY 13.41% FROM 1994 TO 1995

OTOLARYNGOLOGY STATISTICS 1993-1995

MONTH	1993	1994	1995
JAN	61	61	29
FEB	49	56	33
MAR	59	71	54
APR	58	48	37
MAY	63	42	53
JUN	53	39	37
JUL	56	46	40
AUG	65	38	34
SEP	63	27	25
OCT	60	37	28
NOV	56	39	13
DEC	62	33	26
TOTAL	705	537	409

OTOLARYNGOLOGY

MONTHLY STATISTICS 1993-1995



****SURGERIES DECREASED BY 23.83% FROM 1993 TO 1994

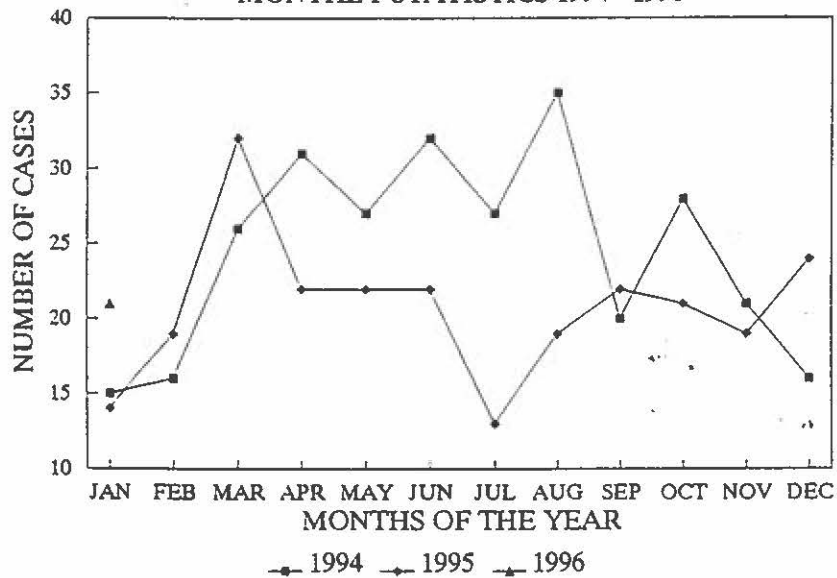
****SURGERIES DECREASED BY 23.84% FROM 1994 TO 1995

UROLOGY STATISTICS 1994-1996

MONTH	1994	1995	1996
JAN	15	14	21
FEB	16	19	
MAR	26	32	
APR	31	22	
MAY	27	22	
JUN	32	22	
JUL	27	13	
AUG	35	19	
SEP	20	22	
OCT	28	21	
NOV	21	19	
DEC	16	24	
TOTAL	294	249	21

UROLOGY

MONTHLY STATISTICS 1994-1996



****SURGERIES DECREASED BY 5.77% FROM 1993 TO 1994

****SURGERIES DECREASED BY 15.3% FROM 1994 TO 1995

**PERCENTAGE OF CANCELLATION
JANUARY-DECEMBER 1995**

MONTH	TOTAL CASES	NUMBER CANCELLED	PERCENT CANCELLED
JANUARY	228	22	9.65%
FEBRUARY	218	32	14.68%
MARCH	296	20	6.76%
APRIL	201	29	14.43%
MAY	244	27	11.07%
JUNE	212	17	8.02%
JULY	207	13	6.28%
AUGUST	209	28	13.40%
SEPTEMBER	156	15	9.62%
OCTOBER	156	23	14.74%
NOVEMBER	147	35	23.81%
DECEMBER	155	17	10.97%
	2429	278	11.45%

**GENERAL SURGERY CANCELLATIONS
JANUARY-DECEMBER 1995**

MONTH	TOTAL CANCELLED	NUMBER CANCELLED	PERCENT CANCELLED
JANUARY	22	6	27.27%
FEBRUARY	32	10	31.25%
MARCH	20	4	20.00%
APRIL	29	12	41.38%
MAY	27	9	33.33%
JUNE	17	5	29.41%
JULY	13	3	23.08%
AUGUST	28	6	21.43%
SEPTEMBER	15	3	20.00%
OCTOBER	23	4	17.39%
NOVEMBER	35	3	8.57%
DECEMBER	17	5	29.41%
	278	70	25.18%

**GYNECOLOGY CANCELLATIONS
JANUARY-DECEMBER 1995**

MONTH	TOTAL CANCELLED	NUMBER CANCELLED	PERCENT CANCELLED
JANUARY	22	7	31.82%
FEBRUARY	32	6	18.75%
MARCH	20	3	15.00%
APRIL	29	5	17.24%
MAY	27	2	7.41%
JUNE	17	1	5.88%
JULY	13	1	7.69%
AUGUST	28	4	14.29%
SEPTEMBER	15	3	20.00%
OCTOBER	23	2	8.70%
NOVEMBER	35	6	17.14%
DECEMBER	17	3	17.65%
	278	43	15.47%

**ORTHOPEDIC CANCELLATIONS
JANUARY-DECEMBER 1995**

MONTH	TOTAL CANCELLED	NUMBER CANCELLED	PERCENT CANCELLED
JANUARY	22	2	9.09%
FEBRUARY	32	1	3.13%
MARCH	20	5	25.00%
APRIL	29	3	10.34%
MAY	27	6	22.22%
JUNE	17	3	17.65%
JULY	13	3	23.08%
AUGUST	28	4	14.29%
SEPTEMBER	15	6	40.00%
OCTOBER	23	6	26.09%
NOVEMBER	35	5	14.29%
DECEMBER	17	3	17.65%
	278	47	16.91%

UROLOGY CANCELLATIONS
JANUARY-DECEMBER 1995

MONTH	TOTAL CANCELLED	NUMBER CANCELLED	PERCENT CANCELLED
JANUARY	22	2	9.09%
FEBRUARY	32	2	6.25%
MARCH	20	1	5.00%
APRIL	29	2	6.90%
MAY	27	4	14.81%
JUNE	17	2	11.76%
JULY	13	1	7.69%
AUGUST	28	3	10.71%
SEPTEMBER	15	1	6.67%
OCTOBER	23	3	13.04%
NOVEMBER	35	6	17.14%
DECEMBER	17	0	0.00%
	278	27	9.71%

OPHTHALMOLOGY CANCELLATIONS
JANUARY-DECEMBER 1995

MONTH	TOTAL CANCELLED	NUMBER CANCELLED	PERCENT CANCELLED
JANUARY	22	2	9.09%
FEBRUARY	32	6	18.75%
MARCH	20	2	10.00%
APRIL	29	3	10.34%
MAY	27	2	7.41%
JUNE	17	2	11.76%
JULY	13	1	7.69%
AUGUST	28	3	10.71%
SEPTEMBER	15	1	6.67%
OCTOBER	23	3	13.04%
NOVEMBER	35	7	20.00%
DECEMBER	17	3	17.65%
	278	35	12.59%

OTOLARYNGOLGY CANCELLATIONS
JANUARY-DECEMBER 1995

MONTH	TOTAL CANCELLED	NUMBER CANCELLED	PERCENT CANCELLED
JANUARY	22	0	0.00%
FEBRUARY	32	3	9.38%
MARCH	20	5	25.00%
APRIL	29	2	6.90%
MAY	27	4	14.81%
JUNE	17	3	17.65%
JULY	13	4	30.77%
AUGUST	28	5	17.86%
SEPTEMBER	15	0	0.00%
OCTOBER	23	2	8.70%
NOVEMBER	35	7	20.00%
DECEMBER	17	1	5.88%
	278	36	12.95%

ORAL SURGERY CANCELLATIONS
JANUARY-DECEMBER 1995

MONTH	TOTAL CANCELLED	NUMBER CANCELLED	PERCENT CANCELLED
JANUARY	22	1	4.55%
FEBRUARY	32	0	0.00%
MARCH	20	0	0.00%
APRIL	29	1	3.45%
MAY	27	0	0.00%
JUNE	17	1	5.88%
JULY	13	0	0.00%
AUGUST	28	1	3.57%
SEPTEMBER	15	1	6.67%
OCTOBER	23	0	0.00%
NOVEMBER	35	0	0.00%
DECEMBER	17	0	0.00%
	278	5	1.80%

CONSCIOUS SEDATION CANCELLATIONS
JANUARY-DECEMBER 1995

MONTH	TOTAL CANCELLED	NUMBER CANCELLED	PERCENT CANCELLED
JANUARY	22	0	0.00%
FEBRUARY	32	4	12.50%
MARCH	20	0	0.00%
APRIL	29	1	3.45%
MAY	27	0	0.00%
JUNE	17	0	0.00%
JULY	13	0	0.00%
AUGUST	28	2	7.14%
SEPTEMBER	15	0	0.00%
OCTOBER	23	3	13.04%
NOVEMBER	35	1	2.86%
DECEMBER	17	0	0.00%
	278	11	3.96%

ESTABLISHMENT OF AMBULATORY PROCEDURES UNIT

The Ambulatory Procedures Unit (APU) was developed as a result of the reengineering of Naval Hospital Charleston in October, 1994. APU centralized all non-invasive and invasive procedures previously performed by the physicians in the Internal Medicine, OB, and General Surgery clinics.

Relocation of Spaces

APU was originally located in the old General Surgery Clinic from October 1994 to January 1995. In January, the unit was moved to 4A (Labor and Delivery and Nursery). The new unit was perfect for the division of invasive and non-invasive procedures. The draw backs identified with the new spaces were the size of the Recovery Room (4 spaces) and the lack of a patient bathroom in the Recovery Room. The unit has proven to be of adequate size with the number of invasive procedures currently performed.

Maximizing Third Party Collections

One of the goals of the APU was to maximize third party collections (TPOC). Previously, the General Surgery Clinic had used sedation as a selection criteria for maximizing TPOC for patients undergoing colonoscopy, bronchoscopy, and EGD. These patients were "admitted" using a short form H&P and processed through the admissions office. The APU staff expanded this program in January, 1995 to include any patient requiring conscious sedation. There was a little concern by the physicians about the paperwork required and complicating an ambulatory

procedure. Since January, we have noticed a decline in the use of sedation. This may be due to declining patient numbers or a reluctance on the part of the physicians to do the paperwork required for sedation. We have been investigating methods to simplify the process while maximizing collections. This would require the use of CPT coding by the TPOC office. As late as October, 1995, information filtered back to us that the demonstration sites using CPT coding were having system problems. We have asked the Alternate Health Care Department to investigate the possibility of Naval Hospital, Charleston becoming a demonstration site.

Pediatric Conscious Sedation

Following the reengineering, APU became the center of activity for pediatric conscious sedation. These children (age range newborn to 10 years of age) usually require sedation in order to perform a radiologic or nuclear medicine study. There was a great deal of discussion about the sedative of choice. Some pediatricians wanted to use Demerol, Phenergan, and Toradol while others felt chloral hydrate was adequate for the types of procedures performed. Since November, 1994, we have used chloral hydrate as our drug of choice. We have performed approximately 72 cases with a 21% (15) cancellation rate and a 8% (6) failure rate. The process for evaluating the child prior to the procedure has changed over the past year. Early in the program, the pediatrician on call was responsible for evaluating the child and ordering the medication. As the number of pediatricians

dwindled, this process changed. The child is now seen by any pediatrician in the team clinic spaces at 0745. The child is then sent to APU with the chart, orders for sedation, and consent form.

Staffing

The final version of the command staffing plan (December, 1994) outlined adequate staffing except for registered nurses. The plan called for one RN for the unit. The number of sedations performed in three procedural rooms and the supervision of the Recovery Room requires at least three RNs. Following the reduction in force and consolidation of the patient care units, two civilian RNs and a military division officer were assigned. Organizationally responsible to the Department Head, Perioperative and Ambulatory Services, APU has also been staffed daily with a perioperative nurse. This has been helpful in standardizing and maintaining perioperative standards in the outpatient setting, establishing appropriate supply inventories, and investigating supply procurement methods that benefit the MOR, Central Sterile Supply, and APU.

Outpatient Support Services

In September, 1995, the Outpatient Support Services Division (OSS) was dissolved. The purpose of this division was to help contain CHAMPUS costs. Originally managed by the Department Head, Alternate Health Care, OSS underwent several changes affecting manning and the services provided. It was determined

that moving OSS to APU offered a better location, improved staffing, and the possibility of expanding services to serve our beneficiaries. Fifty patients remained on the OSS roles. A majority of these patients required supplies and equipment. Five others required periodic visits for central line flushes or medication administration. With the advent of TRICARE, promotion of managed care in the MTF, and hesitancy to pursue Home Health accreditation, APU plans to market its ability to shift certain inpatient procedures to the outpatient setting.

Expansion of Services

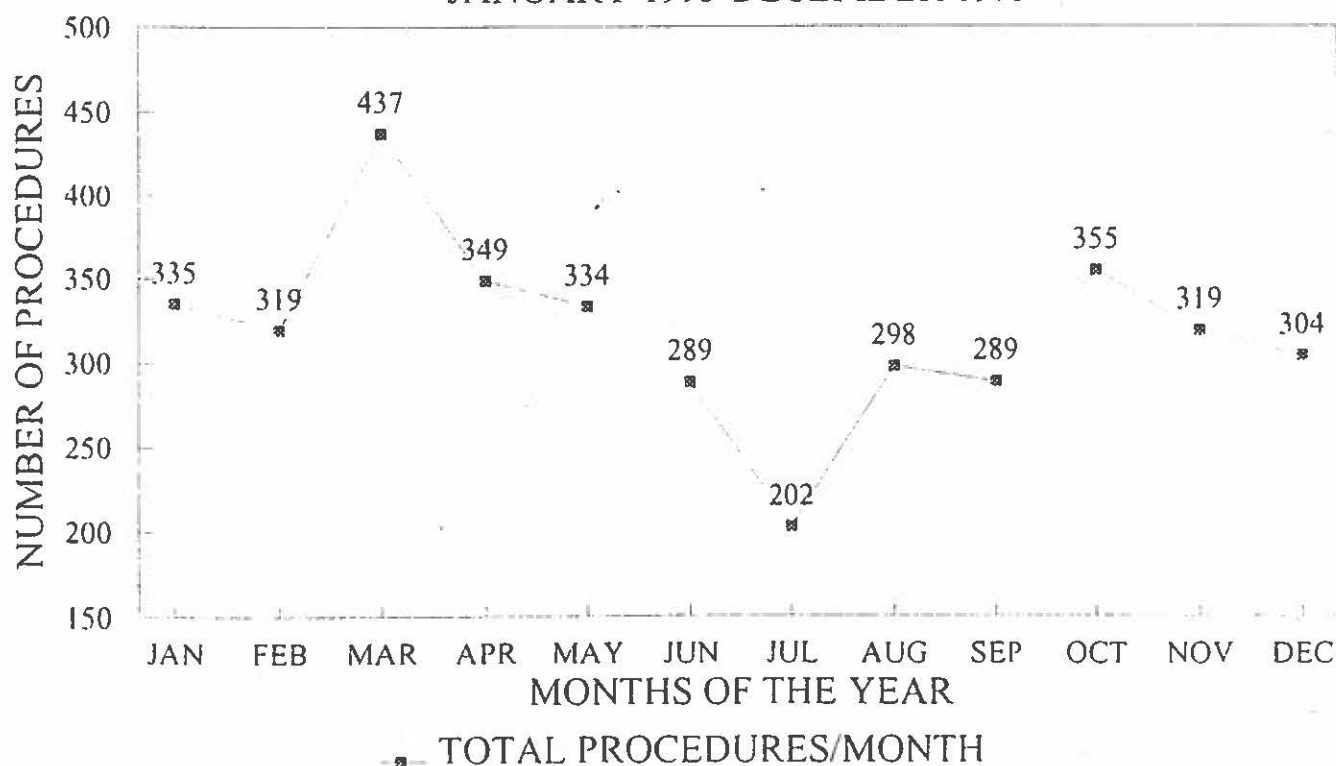
Over the past year, APU has actively campaigned for other surgical specialities to use the invasive procedures lab. Currently General Surgery, ENT and Orthopedics use the spaces. In 1996, the unit plans to add Urology (vasectomy, circumcision, local excisions), Dermatology (tumescent liposuction), and Dental (extractions) procedures. This will concentrate all surgical outpatient procedures in one unit.

AMBULATORY PROCEDURES UNIT NON-INVASIVE PROCEDURES JANUARY 1995-DECEMBER 1995

Studies	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Consults	38	36	37	37	42	36	21	41	31	39	36	30	424
F/U	26	12	35	29	24	23	11	14	16	16	12	19	237
W/I	4	27	6	1	1	3	0	3	1	19	27	19	111
EKG	107	90	139	81	93	83	65	103	92	100	90	94	1137
EST	34	60	65	54	34	40	20	39	46	62	60	43	557
Echo	48	39	56	45	43	40	23	31	37	45	39	34	480
PFT	42	19	49	41	44	24	26	33	30	22	19	17	366
Holter	15	13	24	31	15	14	11	10	12	19	13	13	190
Dapt	17	11	20	20	21	12	13	12	12	10	11	14	173
Telco	2	0	2	0	0	0	0	0	0	1	0	0	5
EEG	2	6	4	7	10	7	5	4	9	5	6	6	71
NST	0	0	0	0	0	0	0	0	0	10	0	11	21
Poly	0	6	0	3	7	7	7	8	3	7	6	4	58
TOTAL	335	319	437	349	334	289	202	298	289	355	319	304	3830

NONINVASIVE PROCEDURE

JANUARY 1995-DECEMBER 1995

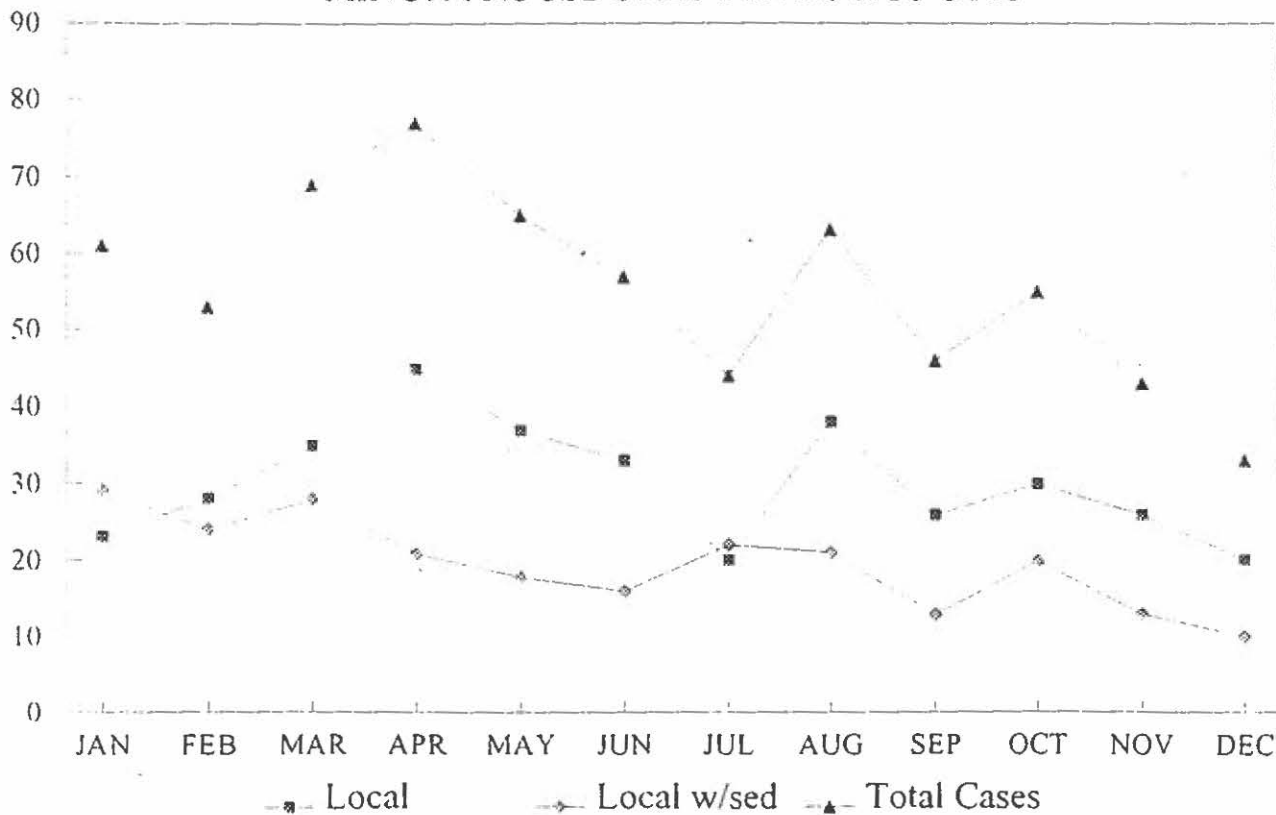


November 95-5 days of furlough

**AMBULATORY PROCEDURES UNIT
MINOR PROCEDURES
JANUARY-DECEMBER, 1995**

MONTH	LOCAL	LOCAL W/SEDATION	NONE	DIGITAL BLOCK	ARM BLOCK	TOTAL
JAN	23	29	4	3	2	61
FEB	28	24	1	0	0	53
MAR	35	28	5	0	1	69
APR	45	21	9	0	2	77
MAY	37	18	9	0	1	65
JUN	33	16	6	0	2	57
JUL	20	22	2	0	0	44
AUG	38	21	2	0	2	63
SEP	26	13	5	0	2	46
OCT	30	20	4	0	1	55
NOV	26	13	4	0	0	43
DEC	20	10	3	0	0	33
TOTAL	361	235	54	3	13	666

**AMBULATORY PROCEDURES UNIT
MINOR PROCEDURES STATISTICS CY95**

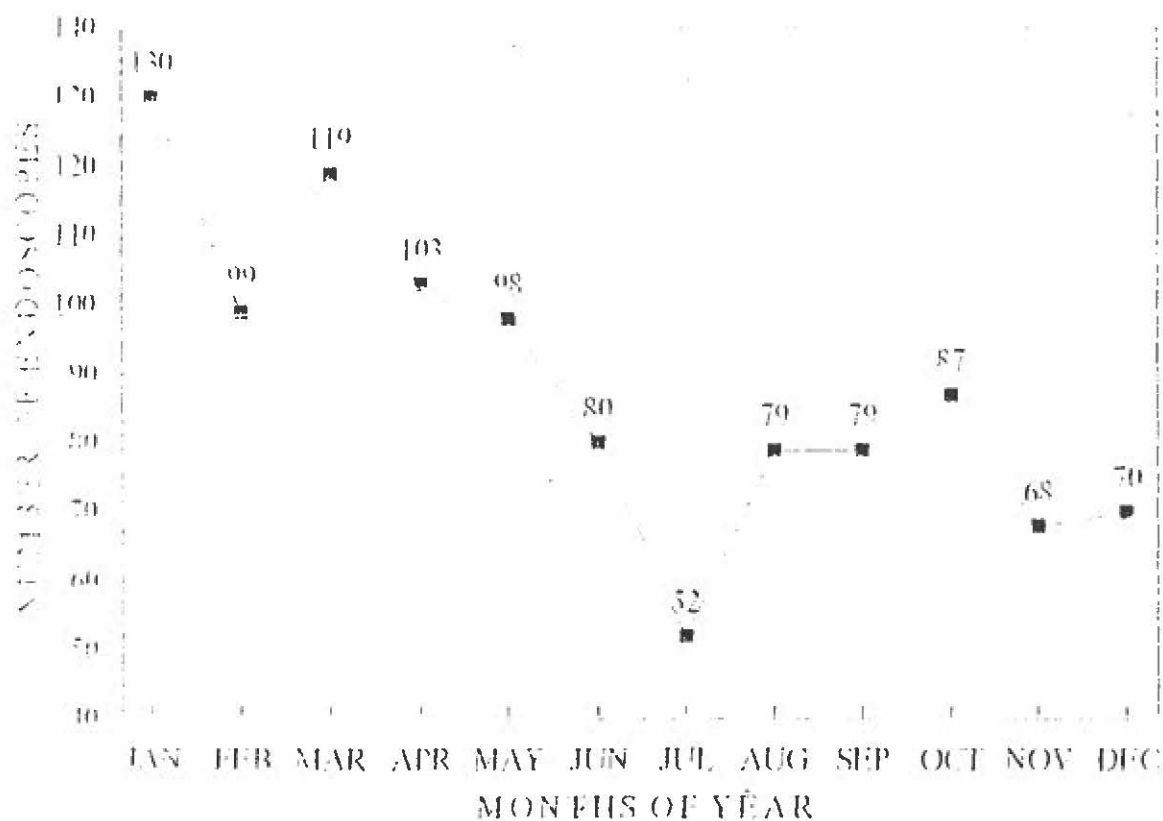


**AMBULATORY PROCEDURES UNIT
ENDOSCOPIC PROCEDURES
JANUARY - DECEMBER 1995**

PROCEDURE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
EGD	17	9	14	19	14	13	8	10	10	17	6	14	151
EGD W/BIOPSY	26	27	27	25	23	12	6	12	17	13	9	15	212
BRONCHOSCOPY	2	0	5	1	1	2	1	2	0	1	2	1	18
BRONCHOSCOPY W/BIOPSY	1	1	2	0	0	0	1	1	0	2	0	1	9
COLOIDOSCOPY	46	29	28	21	32	22	10	26	22	20	35	17	308
COLOIDOSCOPY W/BIOPSY	12	12	16	18	11	15	8	11	13	20	7	10	153
FLEXIBLE SIGMOID	20	16	23	12	10	13	11	12	14	10	8	10	159
FLEX SIG W/BIOPSY	5	4	4	3	6	3	7	5	3	4	1	2	47
ANOSCOPY	0	1	0	0	0	0	0	0	0	0	0	0	1
UPPER GI	0	0	0	3	0	0	0	0	0	0	0	0	3
DILATION	1	0	0	1	1	0	0	0	0	0	0	0	3
TOTAL	130	99	119	103	98	80	52	79	79	87	68	70	1064

ENDOSCOPIC STATISTICS

JANUARY - DECEMBER 1995



■ TOTAL NUMBER/MONTH

COMMAND ORIENTATION

PUBLIC AFFAIRS

I. Internal Media

A. Hospital Newspaper - Southern Starship

1. Published monthly
2. Articles accepted by the 5th day of each month
3. Writers & photographers needed

B. Posting of items on bulletin boards

1. Approval from PAO
2. Posted for a limited time only
3. Personal ads for hospital staff only

II. External Media

A. Publishing of Professional Articles

B. Interaction with media

1. Post & Courier advertising
2. Press Releases
3. News Articles/Stories

III. Volunteer Programs

A. Community Service and Volunteer Programs

1. Burns Elementary School - Partnership

- a. Mentoring
- b. Tutoring
- c. Special Projects
- d. Health Promotions

2. American Red Cross - Volunteer Opportunity
3. People Against Rape - Volunteer Advocate Opportunity
4. Feed the Hungry
5. Operation Shipmate
6. Clean Sweep
7. Adopt-a-highway
8. North Park Recreation Group
9. Help Bank - Chapel

Volunteer Programs

E.A. Burns Elementary School

School POC: Principle, Mr. Davis 745-7113

Hospital POC: Lynn Treadway 743-7264

Provide four areas of support:

- Tutoring
- Mentoring
- Special Projects
- Health Promotions

Volunteers needed in all four areas.

American Red Cross

Red Cross POC: Mr. Whitfield 744-8021

Hospital POC: Lynn Treadway 743-7264

The Red Cross has an Agreement with the hospital to provide volunteer support to the Navy Hospital and Branch Clinics:

- Provide office space for Red Cross Volunteers.

- Provide staff support.

- Offer volunteer opportunities to military and their dependents, civil service employees or any other civilians that may be interested in volunteering.

Ombudsman

Hospital POC: Connie Newbauer 553-0110

Provide support to the families of military staff members.

People Against Rape

PAR POC: Alexia Niketa 722-7273

Hospital POC: Vacant

The purpose of this agency is to provide crisis intervention and advocacy services to rape victims and their families; to provide follow-up accompaniment and act as liaison between victims and medical, police and legal systems; to present community education programs and in-service programs for professionals who work with rape victims and their families; and, to advocate for systems change to improve rape victim services. The Navy Hospital provides volunteer support in the form of advocates:

Volunteers needed to be advocates.

Clean Sweep

Hospital POC: TBA

Provide volunteer support:

- Volunteers needed to assist in cleaning local beaches, roadsides, etc.

Adopt-A-Highway

Hospital POC: TBA

Provide volunteer support:

- Volunteers needed to assist in the maintenance of a designated section of road in the Charleston area.

Elks Lodge

Lodge POC: Frank DiFiglio 795-1078

Hospital POC: Lynn Treadway 743-7264

Provide facility support:

Provide storage room for their supply's.

Assist in setting up special events during the holidays for patients.

North Park Recreation Group

Hospital POC: HM3 Jerome Conner 743-7038

Provide a recreation program and after school education in tutoring, computer skills, etc...

Southern Starship - Hospital Newspaper

Hospital POC: Editors, Lynn Treadway 743-7264

HN Lana DeGenova 743-7952

Monthly newspaper consisting of health and safety related articles as well as other items of interest to the hospital staff.

Volunteer reporters, writers and photographers needed.

COMNAVBASE Retired Affairs Office
Post Retirement Seminar
8 April 1995
Naval Hospital Charleston
Questions & Answers

Q2. When shifting from CHAMPUS to MEDICARE; how do we obtain prescription drugs and insulin when covered by MEDICARE?

A2. Unfortunately, MEDICARE does not generally cover the cost of outpatient prescription drugs. The Pharmacies at the Naval Hospital and the Charleston Air Force Base will continue to accept civilian provider prescriptions that are carried on their formularies. If a civilian provider writes a prescription which requests a pharmaceutical not carried on the formulary, the patient may have some options. The patient can request the civilian provider to rewrite a prescription for a pharmaceutical which is carried on our formulary.

MEDICARE eligible beneficiaries living in a Base Realignment and Closure (BRAC) site, such as Myrtle Beach, may use the DoD mail order pharmacy benefit. For a small copayment, the patient can use the mail order pharmacy and will be able to obtain up to a 60 day supply of pharmaceuticals. Information and eligibility requirements can be answered by calling 1-800-633-2646 (1-800-MED-CHAM).

Additional information about MEDICARE benefits can be received by contacting a Social Security Administration Office.

Q4. When will TRICARE be implemented in Charleston?

A4. TRICARE will be implemented in DoD region 3, which covers South Carolina, Georgia, and parts of Florida, in May 1996. TRICARE is the DoD Managed Care Program which offers together the health care delivery systems of each of the military services, as well as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), in a cooperative and supportive effort to better serve military patients and to better use the resources available to military medicine. In addition to the HMO option, TRICARE Prime, there are TRICARE Extra and TRICARE Standard.

TRICARE Prime is the voluntary enrollment option that offers patients the advantages of managed health care, such as primary care managers, assistance in making specialty appointments, and someone else to do their claims filing. The Prime option offers the scope of coverage available today under CHAMPUS, plus additional preventive and primary care services. For Prime enrollees, the new cost sharing provisions do away with the usual standard CHAMPUS cost sharing. Of particular note, families of active duty personnel will have no enrollment fees. CHAMPUS-eligible retirees who enroll in Prime will pay an enrollment fee. For Prime enrollees there will be copayments for care received from civilian providers.

CHAMPUS-eligible beneficiaries may elect to enroll in TRICARE Prime on an annual basis. The other two choices for

health care delivery under TRICARE are:

TRICARE Standard - This option is the same as the standard CHAMPUS program.

TRICARE Extra - In the TRICARE Extra program, when a CHAMPUS-eligible beneficiary uses a preferred network provider, he/she receives an out-of-pocket discount and usually does not have to file any claim forms. CHAMPUS beneficiaries do not enroll in TRICARE Extra, but may participate in Extra on a case-by-case basis just by using the network providers.

Currently, MEDICARE eligible retirees are not eligible to enroll in TRICARE Prime.

Q12. Can retirees obtain copies of their individual medical records from the Naval Hospital?

A12. Yes. Anyone can request a copy of their medical record. The first copy is free and is generally available within five working after the request is received. The second copy is \$8.30 plus 10 cents per page. Due to Privacy Act requirements, you cannot request a copy of your spouse's medical record unless you have your spouse's written permission. You can request a copy of your dependent child's medical record if you are the custodial parent.

Q13. Why when my family and I go to a MTF or NAVCARE is my private insurance billed for the visit? It raises my premiums!

A13. Using your private insurance at the Naval Hospital will not raise your premiums directly. Private insurance premiums are generally based on a group rating. As health care costs for the entire group increases, the costs of premiums will generally increase for the entire group. By billing private insurance companies, the Naval Hospital receives additional funds for local use. These additional funds are used to purchase needed equipment and help to increase the availability of health care services. Under Public Law 101-510 (10 U.S. Code 1095), Congress directs military hospitals to bill private insurance companies for the cost of care provided by the military facility. You cannot be charged a deductible or co-payment for the care received through the military facility. The government will absorb these costs. Therefore, claims filed by the government for care you receive may count towards meeting your deductible. This may result in a significant savings to you if you later seek civilian care.

Q16. Why doesn't CHAMPUS cover Chiropractic care?

A16. CHAMPUS has, in the past, sponsored demonstration projects in selected states to assess the feasibility of covering Chiropractic care. At this point Chiropractic Care is not a covered benefit under CHAMPUS.

Q17. Why isn't there a prescription medicine outlet in Summerville area where a few hundred retirees live?

A17. The Naval Hospital would love to provide medical services to our beneficiaries that would best meet the beneficiaries needs. Like other services and organizations within the Department of Defense (DoD), the Naval Hospital is reducing capacity in its infrastructure to support a smaller, efficient and effective force structure. As a result of the reducing active duty military population in the Charleston area and an expected reduction in the hospital's inpatient capacity, the Naval Hospital Charleston is reducing its overall staffing levels.

The Naval Hospital is exploring different ways to meet our customer's needs. We are exploring the possibility of opening a pharmacy outlet on the Naval Weapons Station.

ATTENTION MILITARY BENEFICIARIES

**** BLUE TEAM CONSOLIDATION AT THE NAVAL HOSPITAL CHARLESTON**

Effective 1 July 1995, the Blue Team is being permanently consolidated with our other primary care sites. This is due to the downsizing of Naval Hospital staff related to the Naval Base closure, deployment of Naval Hospital personnel to Cuba and normal summer rotation of our military providers. If you have been assigned to the Primary Care Group Practice Blue, you will automatically be reassigned to either the Red Team, Gold Team, Primary Care Clinic (Green Team) or the Naval Weapons Station Branch Medical Clinic.

If you were assigned to the Blue Team, you should receive a letter in the near future telling you where your new primary care assignment is located. If you have any questions, or if you need to schedule an appointment, please call Health Care Finders at 743-3709.

**** RELOCATION OF THE SURGERY/OBSTETRIC/GYNECOLOGY CLINICS**

Effective 5 July 1995, the physician specialties of Surgery, Obstetrics, and Gynecology will move from the primary care teams on the first floor to a separate location on the fourth floor of the Naval Hospital. Beneficiaries assigned to a primary care team will maintain an assignment to a primary care team. Beneficiaries requiring Surgical, Obstetric or Gynecological care can be referred by a primary care provider or can call Health Care Finders at 743-7309 for additional information.



DEPARTMENT OF THE NAVY

COMMANDER NAVAL BASE

CHARLESTON, SOUTH CAROLINA 29408-5100

2 June 1995

From: Commander, Naval Base, 1690 Turnbull Avenue, Suite A,
Charleston, SC 29408-1955

To: All Attendees

Subj: MINUTES OF THE 3 MAY 1995 HEALTH CARE CONSUMER COUNCIL
MEETING

1. The meeting was convened at 1000, 3 May 1995, in the auditorium of Sterett Hall, Naval Base, Charleston. LT David Dula, Naval Hospital, served as moderator. He welcomed all attendees, provided related handouts and described their contents. The handouts included a feedback questionnaire for attendees to complete and return.

2. CAPT Etienne, Commanding Officer, Naval Hospital, Charleston welcomed all attendees and introduced the panel. After reviewing some of the changes made at the hospital during the past two years, the future role of the hospital was discussed. The hospital will remain open and its mission will remain the same -- to keep the active duty members healthy and to provide health care for their families and other beneficiaries.

a. The number of operating beds has been decreased from 200 to 90 during the past two years and will be further reduced to 65 by the end of 1996. The alcohol rehabilitation clinic has been closed. Under new partnership agreements, the obstetrical deliveries have been transferred to the Trident Hospital and the psychiatric services have been transferred to the Veterans Administration. Specialized departments have been replaced by four Primary Care Teams to increase availability of services and continuity of care.

b. Medical practices and advanced technology have brought about changes in medicine. The average patient stay has decreased and, now, nearly 50 percent of patients go home the same day.

c. The Shipyard Branch Clinic may remain open a bit longer after departure of the USS NICHOLSON to provide service to remaining personnel needed to process base closure. The clinic's Occupational Health staff will relocate to the Naval Hospital and Naval Weapons Station.

2. LCDR C. M. Howard, Assistant CAMCHAS Project Officer, Naval Hospital, Charleston discussed TRICARE, the joint-military/civilian health care network for the Charleston Area, which will be available in 1996. The network is a managed care-type

PROFESSIONAL AND PROUD

Subj: MINUTES OF THE 3 MAY 1995 HEALTH CARE CONSUMER COUNCIL
MEETING

health maintenance organization (HMO). The three available options were discussed and handouts were provided showing specific benefits by pay grade (E-4 and below, E-5 and above, and retirees, survivors and families). Benefit structure will be the same across the country.

a. TRICARE Standard (CHAMPUS) features care on space-available basis at military facilities, individual out-of-pocket costs at 25 percent (highest of the three options), and claims paperwork.

b. TRICARE Extra (Health Care Finders/CAMCHAS) provides care at a military facility on space-available basis, offers use of a preferred provider network at out-of-pocket cost savings of 5 percent, and usually involves no paperwork for claims.

c. TRICARE Prime offers a cost-saving enrollment option with the Medical Treatment Facility (MTF) space entitlement, no claims paperwork, low out-of-pocket costs, mail-in pharmacy capability, and more immunization coverage for children, etc. Also, the enrollee has the option to go outside the HMO network at an additional cost.

3. CAPT J. J. Simkovich, Executive Officer, Naval Dental Center, Charleston discussed upcoming transfer of dental services to the Naval Weapons Station. At the end of June 1995, Dental Center staffing will be down to five, and services will continue through 14 July. After this date, there will be two trailers and a mobile dental van at NWS to service the remaining active duty population on a daily basis. No dental lab will be available. One dentist will be available at the Air Force Base and, hopefully, we will be able to use that facility as well. Care will be on standby basis. Emergency services are no longer available for retirees. Expansion of facilities is planned.

4. Ellen Baker, Coordinated Care, Naval Hospital, provided an update on CHAMPUS:

a. A new contractor has been assigned to the active duty Dental Plan (formerly Delta Dental). No changes are anticipated. Health care for active duty dependents are expected to continue.

b. A new CHAMPUS rule is in effect for Ambulatory Surgery. Some diagnoses for CPC have changed, and some codes are no longer authorized by CHAMPUS. If surgery is planned, a check with CHAMPUS will be necessary to see if the diagnoses are covered.

Subj: MINUTES OF THE 3 MAY 1995 HEALTH CARE CONSUMER COUNCIL
MEETING

c. Health Care Finders is now making NAVCARE appointments and an information desk is available on sixth floor of the Naval Hospital.

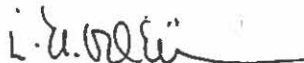
d. The Alternate Health Care Department is available to give briefings to organizations to promote understanding of its services.

5. HMC R. L. Krunich, Naval Hospital's Patient Contact Representative, discussed the role of the patient contact representative. Patient contact representatives are assigned to various departments and areas of the hospital, and they are identified in those areas with pictures and descriptions of their duties. The representatives are available to hear patient problems and concerns. HMC Krunich coordinates resolutions between the departments. Written comments, suggestions, and concerns are also received. Presently, the Commanding Officer, Naval Hospital, has two suggestion boxes: one is located in the front lobby near the quarterdeck and the other one is in the Pharmacy lobby.

6. A number of questions were received from the audience.

7. LT Dula thanked everyone for their attendance and the meeting was adjourned.

8. The next Health Care Consumer Council Meeting is scheduled for 2 August 1995 in the auditorium of Sterett Hall, Naval Base, Charleston. If you have any topic suggestions for future council meetings, please contact LCDR D. C. B. Albia, at 743-7307.



L. N. ODEN

COMNAVBASE Health Care Consumer Council



Naval Hospital
Briefing
6 Sept 1995

HEALTH CARE CONSUMER COUNCIL

6 SEP 95

AGENDA

MODERATOR

ENS J. G. DAVIS

WELCOME

CAPT K. L. MARTIN
Commanding Officer
Naval Hospital

OPENING REMARKS

CAPT S. W. MALLEY
Executive Officer
Naval Dental Center

Col D. J. COOK
Chief of Staff,
437th Airlift Wing
Charleston Air Force Base

Col W. T. SANDERS II
Commander, 437th
Medical Group
Charleston Air Force Base

RADM L. N. ODEN
COMNAVBASE
Charleston

SPEAKERS:

TRICARE

LTJG R. SUMTER

DENTAL CARE

CAPT S. W. MALLEY

NAVCARE

MS. MARILYN KRAUSE

CLOSED MED. REC. SYS.

MS. DEBORAH ROSZELL

QUESTIONS/ANSWERS

PANEL

CLOSING REMARKS

ENS J. G. DAVIS

FEEDBACK SHEET

	CIRCLE A RESPONSE BETWEEN 1 & 4 WHICH BEST INDICATES HOW IMPORTANT THIS TOPIC IS TO YOU				CIRCLE A RESPONSE BETWEEN 1 & 4 WHICH BEST DESCRIBES HOW INFORMATIVE THIS PRESENTATION WAS FOR YOU			
	1 = VERY UNIMPORTANT 2 = SOMEWHAT UNIMPORTANT		3 = SOMEWHAT IMPORTANT 4 = VERY IMPORTANT		1 = VERY UNINFORMATIVE 2 = SOMEWHAT UNINFORMATIVE		3 = SOMEWHAT INFORMATIVE 4 = VERY INFORMATIVE	
TRICARE	1	2	3	4	1	2	3	4
DENTAL CARE	1	2	3	4	1	2	3	4
NAVCARE	1	2	3	4	1	2	3	4
CLOSED MEDICAL RECORD SYSTEM	1	2	3	4	1	2	3	4
QUESTIONS & ANSWERS	1	2	3	4	1	2	3	4

1. IS THERE A TOPIC(s) WHICH YOU WOULD LIKE TO HAVE SEEN IN THE PRESENTATION? IF SO, PLEASE LIST BELOW.

2. WHAT ONE THING DID YOU REALLY LIKE ABOUT THE HEALTH CARE CONSUMER COUNCIL?

3. WHAT ONE THING COULD HAVE BEEN BETTER ABOUT THE HEALTH CARE CONSUMER COUNCIL?

4. WOULD YOU LIKE SOMEONE TO CONTACT YOU ABOUT A SPECIFIC QUESTION? IF SO, PLEASE COMPLETE YOUR NAME AND PHONE NUMBER.

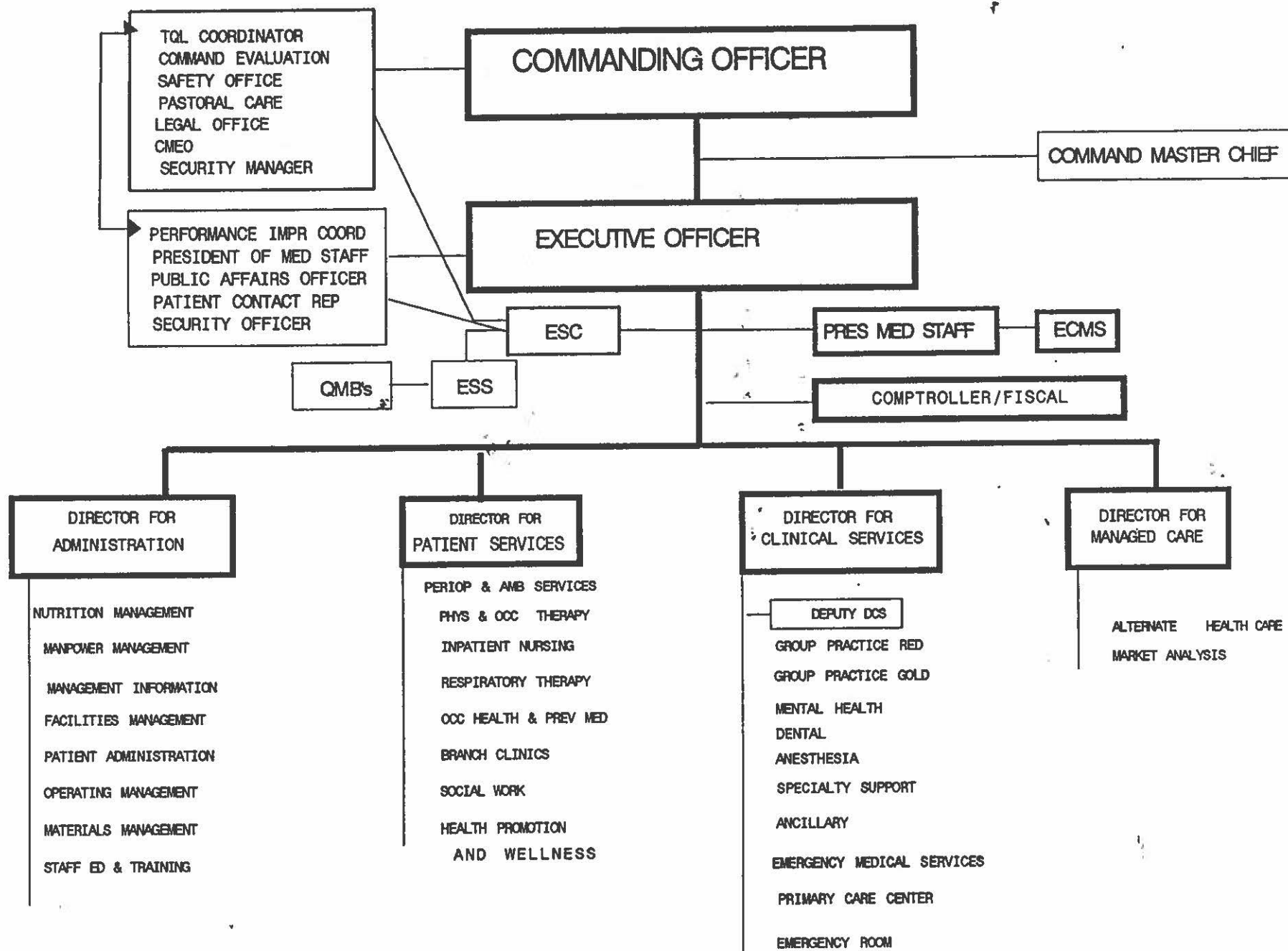


Naval Hospital Briefing

23 AUG 95

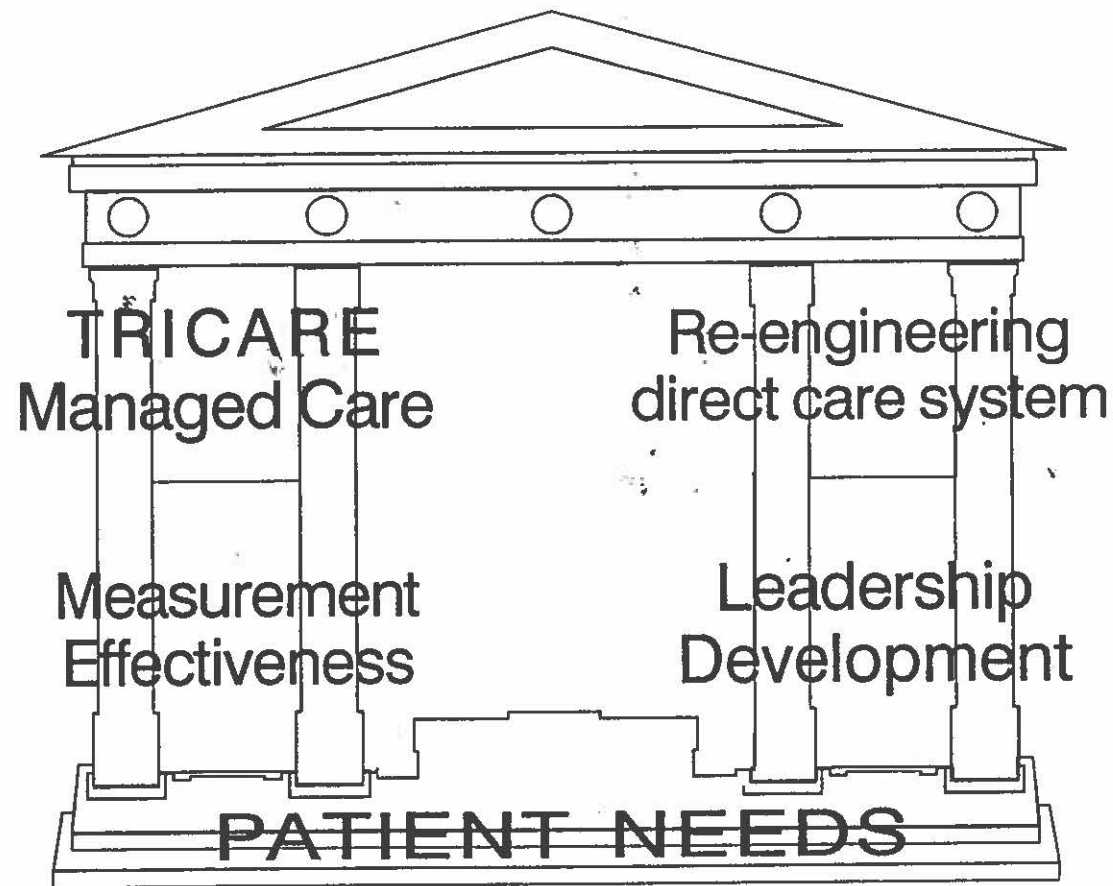
Vision Statement

Our vision is to be the
model primary care community
hospital in an integrated
Department of Defense managed
healthcare delivery system.



TRI-CARE STRATEGIC PILLARS

CHARLESTON PLAN FOR MILITARY MEDICINE

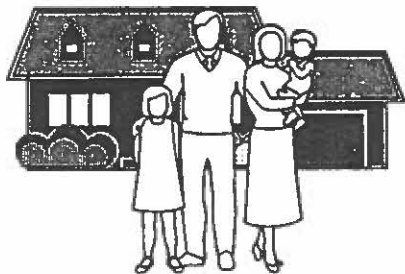


ENABLING STRATEGY

IMPORTANT NOTICE TO MILITARY BENEFICIARIES

HOW TO OBTAIN PRIMARY HEALTH CARE IN CHARLESTON

Assigned Military Families



HELP INFO
CENTRALIZED APPOINTMENTS
PRIMARY HEALTH CARE





Health Care Finders

743-3709



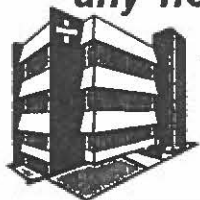
PRIMARY HEALTH CARE

PRIMARY CARE PROVIDERS

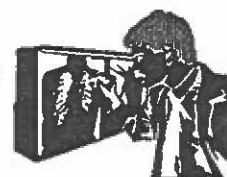
 NAVCARE CLINIC 572-0169	 Group Practice Red Navy Hospital 743-7479	 Group Practice Gold Navy Hospital 743-7090	 Primary Care Center Navy Hospital 743-7999	 Family Practice Naval Weapons Station 764-7633	 437th MED GRP Charleston Air Force Base 566-2775
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LIFE OR LIMB-THREATENING EMERGENCY MEDICAL CARE

**Naval Hospital
Emergency
Department or
any hospital
ER.**



- Inpatient Care
- In-house Specialists
- Network Providers
- DoD Referrals



NH Charleston

Naval Hospital Charleston

A Premier Managed
Health Care
Delivery System

PLAN FOR PRIMARY CARE

- PRIMARY CARE BASED SYSTEM
 - Empanelment
- PRIMARY CARE (GROUP PRACTICE) TEAMS
 - 3 Teams (Red, Gold, Green)
 - Multi-Speciality
 - Utilize Physician Extenders
- HEALTH CARE PROMOTION
 - Educate/Self Help
 - Screening Clinics
 - Full Time Health Promotion Department

CAMCHAS

Catchment Area Management Charleston

- Over 900 providers within the Trident area participate in the CAMCHAS Demonstration Project
- Health Care Finders is the focal point for accessing primary and specialty care.
- All participating providers agree to accept discounted rates (below CHAMPUS maximum allowable), to file claims for beneficiaries, and not balance bill patients.
- Foundation for future Tri-Care Program.

External Factors

Impacting Hospital

- Effects of BRAC
- Rightsizing of military
- Shifting of beneficiary composition
- Capitation budgeting
- Impact of healthcare reform (TRICARE)
- DoD Regionalization



City of Charleston
South Carolina

NEWS RELEASE: Charleston Naval Hospital to Remain
FOR RELEASE: August 24, 1995
FOR FURTHER INFO: Contact Barbara W. Vaughn, Public Information Coordinator, 724-3746.

Mayor Joseph P. Riley announced today that confirmation has been received from The Bureau of Medicine and Surgery for the Department of the Navy that the Charleston Naval Hospital, originally scheduled to be realigned as a "Super Clinic" under Department of Defense Health Programming Actions, will remain open as a hospital. In June of 1995, Mayor Riley wrote Dr. William Perry, Secretary of Defense, concerning information that was discovered in the BRAC Library by the In Defense of Charleston Team. That information indicated that the Assistant Secretary of Defense for Health Affairs had recommended the realignment of five naval hospitals, including Charleston Naval Hospital to super clinic status outside of BRAC proceedings. This action would have directly affected more than 300 civilian employees at the Charleston Naval Hospital.

The realignment of CNH to super clinic status was projected to cost the Department of Defense approximately \$57 million annually for additional charges under the Champus program. It is estimated that even with the formal closure of the Naval base and Shipyard, Charleston Naval Hospital will still serve over 71,000 beneficiaries including active duty military at Charleston Air Force Base, Naval Weapons Station, Nuclear Power Training School, and the Army Prepositioning Depot. Additionally, over 20,000 active duty dependents would also need service. Major military medical facilities hold down steep rises in CHAMPUS costs. Clinics cannot perform that function as well since they are not manned to perform all of the requisite medical specialties and do not have 24 hour care available.

Mayor Riley additionally contacted President Bill Clinton's office seeking his assistance as well. Mayor Riley said, "Jobs for over 300 civilians have been saved and a valuable and irreplaceable service for current and former members of the military and their families has been preserved. I would also like to express my sincere appreciation and congratulations to General Claudius E. Watts and Admiral David Emerson, and all the members of the In Defense of Charleston hospital team for their diligence and perseverance on behalf of Charleston Naval Hospital. "

He expressed his gratitude to President Clinton and Secretary Perry for realizing the importance of Charleston Naval Hospital. Mayor Riley also recognized the fine job currently being undertaken by the Charleston Naval Hospital as a joint Air Force and-Naval medical facility under the very capable medical leadership of Capt. Kathleen Martin.

*City of Charleston**Joseph P. Riley, Jr.
Mayor*OFFICE OF THE
95 JUN 13 PM 1:21

June 5, 1995

The Honorable William J. Perry
Secretary, Department of Defense
The Pentagon
Washington, D.C. 20301

Dear Dr. Perry:

As you know, the Charleston metropolitan area was very hard hit in the 1993 base closure round. We were fortunate to be able to convince the Base Closure and Realignment Commission that the Charleston Naval Hospital was important to the remaining military within the Charleston metropolitan area. The Charleston Air Force Base has over 6,000 active duty personnel, and the Naval Weapons Station will have a similar number of personnel, giving a total of 11,000 active duty and 16,000 active duty dependents in the area. Additionally, it is apparent that over 62,000 beneficiaries will be served by the Naval Hospital.

In testimony at the BRAC Service Hearings on March 6, 1995, both the Secretary of the Navy and the Secretary of the Air Force cited U.S. Naval Hospital Charleston as a shining example of joint manning. The current XO of USNH Charleston is a Colonel, U.S. Air Force, and the hospital is scheduled to receive more USAF medical personnel as part of its staff during the summer of 1995.

My reason for bringing you the benefit of this information is that a routine May 10, 1995 visit to the BRAC Library resulted in the discovery of an April 11, 1995 memo signed by Dr. Edward D. Martin, Principal Deputy, Assistant Secretary of Defense (Health Affairs), a copy of which is attached. As you can see, that memo has indicated that Naval Hospital Charleston is scheduled to realign as a "super clinic". This information was provided to the Base Closure and Realignment Commission as a result of their review of all military hospitals throughout the United States.



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City of Charleston, South Carolina 29401 803-577-6111

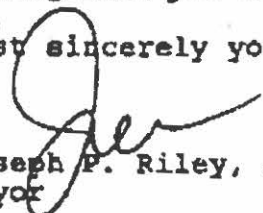
The Honorable William J. Perry
June 5, 1995
Page Two

While we certainly realize that downsizing the military means that there is not as great a need for medical facilities, I would submit that the fact that this hospital is the nearest military hospital to a military air logistics base in the continental U.S. east of the Mississippi River, plus the jointness issue mentioned above and the number of beneficiaries, certainly does not indicate that the hospital should be downsized to a "super clinic". With cost-cutting efforts underway, it appears that the downsizing does not take into account the fact that the cost of realignment of the Charleston Naval Hospital to a "super clinic" would be in excess of \$57 million per year. This figure includes CHAMPUS plus costs paid for active duty personnel to be treated in civilian medical facilities. The USNH Charleston (and all major military treatment facilities) serve as very useful facilities within their catchment areas. Historically, they prevent steep rises in CHAMPUS costs for military treatment. The clinic could not perform that function, for it would not provide specialty care, which is cheaper in a military hospital.

Since this change appears imminent and is outside the BRAC, your urgent attention is requested. We feel that it is critical to the well-being of the active duty military who will be in Charleston, as well as the new Nuclear Power Training Command scheduled to realign to Charleston. Also, a further review of the costs is in order, since substantial increases in service costs would result with the downsizing to a "super clinic".

I would be happy to further discuss this issue with you at your convenience, and I look forward to hearing from you in the near future.

Most sincerely yours,



Joseph P. Riley, Jr.
Mayor

JPR, Jr/mj

Attachment



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

6010

Ser 312/95128043190

2 Aug 95

The Honorable Joseph P. Riley, Jr.
Mayor of Charleston
P.O. Box 652
Charleston, SC 29402

Dear Mayor Riley:

I am following up your letter of June 5, 1995 to the Secretary of Defense, William J. Perry concerning the future of Naval Hospital, Charleston.

On July 13, 1995 Rear Admiral Noel Dysart provided you with information about on going Navy actions to determine the best way for us to meet our obligations to DoD Health Care beneficiaries in the Charleston area. At this time no decision has been made to make any change in our current level of operations. Should any change take place in the future it will be proceeded by full notification of all interested parties and the establishment of a system that will assure our beneficiaries of appropriate access to high quality cost effective care.

If I can be of further assistance please do not hesitate to contact me.

Sincerely,

A handwritten signature in dark ink, appearing to read "H. E. Phillips".

H. E. PHILLIPS
Captain, Medical Service Corps
Assistant Chief for
Health Care Operations

AUG-24-1995 13:49
AUG-23-1995 09:49

OFFICE OF THE MAYOR
TRAFFIC & TRANSPORTATION

803 720 3827 P.07
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HEALTH AFFAIRS

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

APR 11 1995

MEMORANDUM FOR OFFICE OF THE ASD (ECONOMIC SECURITY)
ATTN: DIRECTOR, BASE CLOSURES

SUBJECT: Defense Base Closure and Realignment Commission Request for Information

During a recent meeting, the Defense Base Closure and Realignment Commission staff requested information regarding initiatives to reduce Military Health Services System infrastructure through other means than the base realignment and closure process. The attached information responds to this request (attachment 1). In addition the Commission staff requested the attached information regarding the "733 Study" and the economic analysis conducted in regards to Fitzsimons Army Medical Center (attachments 2, 3).

This attached information was not part of the base closure and realignment decision making process and therefore is not subject to certification.

The point-of-contact for additional information is LTC Richard A. Jones or LTC Edward Ponatoski, (703) 614-4705.

Edward D. Martin

Edward D. Martin, M.D.
Principal Deputy Assistant Secretary

Attachments:
As stated

Medical Base Realignment
and Closure 1995

Joint Cross Service Group for
Medical Treatment Facilities and
Graduate Medical Education

MHSS Infrastructure Reductions (FY 88 - FY 97)

- Baseline - FY 88 Health Facility Planning Review
- Normal beds decreased by ~12,000, or 43%
- Expanded beds decreased by ~20,000, or 48%
- Number of hospitals decreased by 58 facilities, or 35%

• Includes DHP Program Initiatives and BRAC 95

Programming Actions and BRAC 95 Reductions

■ DHP Programming Actions -

- | | |
|--------------------|-------------------------|
| - NH Charleston | Realign to super clinic |
| - NH Corpus Cristi | Realign to super clinic |
| - NH Groton | Realign to super clinic |
| - NH Millington | Realign to super clinic |
| - NH Pax River | Realign to super clinic |

■ BRAC 95*

- | | |
|----------------|-------------------------|
| - FAMC | Closure |
| - Ft McClellan | Closure |
| - Reese AFB | Closure |
| - Ft Lee | Realign to super clinic |
| - Ft Meade | Realign to super clinic |

* Indicates Service Concurred Alternatives

MHSS Infrastructure Reductions

1988 HEALTH FACILITY PLANNING REVIEW				
	# HOSP	OPER	NORMAL	EXPANDED
AIR FORCE	82	5,219	9,124	11,371
ARMY	50	7,781	11,647	19,231
NAVY	36	4,164	7,758	11,446
TOTALS	168	17,164	28,529	42,048

	# HOSP	OPER	NORMAL	EXPANDED
CURRENT INVENTORY	110	10,040	16,894	22,861
REDUCTIONS SINCE 1988	58	7,124	11,635	19,187
% DECREASE SINCE 1988	35%	42%	41%	46%

MTF/GME JCSG Reduction Targets/Goals

- Overarching goal is to minimize excess capacity
- Close MTFs and reduce infrastructure as Military Departments close bases
- Eliminate excess capacity
 - in overlapping catchment areas
 - where realignment/rightsizing opportunities present themselves as a consequence of Service decisions

